

Assembly Bill No. 2780

CHAPTER 310

An act to amend Section 2290.5 of the Business and Professions Code, to amend Sections 11019, 95001, 95007, 95012, 95016, 95018, and 95020 of the Government Code, to amend Sections 1179.2, 1179.3, 1265.5, 100171, 101230, 101300, 101305, 103640, 123975, 125000, and 125070 of, to add Sections 1179.5, 1250.05, 104569, and 124560 to, to add Article 6.5 (commencing with Section 124115) to Chapter 3 of Part 2 of Division 106 of, and to add Chapter 4 (commencing with Section 53250) to Part 4 of Division 31 of, the Health and Safety Code, to amend Section 12693.95 of, and to add Chapter 16.1 (commencing with Section 12693.98) to Part 6.2 of Division 2 of, the Insurance Code, to amend Sections 4434, 4596.5, 4629, 4631, 4635, 4640.6, 4681.3, 4690.2, 4691.5, 4701, 4702.6, 4704, 4704.5, 4705, 4710.5, 4710.6, 4710.7, 4710.8, 4711, 4712, 4712.5, 4715, 14005.8, 14016.5, 14067, 14100.7, 14105.31, 14105.33, 14105.35, 14105.37, 14105.38, 14105.39, 14105.4, 14105.405, 14105.41, 14105.42, 14105.91, 14105.915, 14105.916, 14124.70, 14124.72, 14124.74, 14124.75, 14124.78, 14132.44, 14132.47, 14132.72, and 14163 of, to add Sections 4433.5, 4511, 4513, 4681.4, 4681.5, 4690.3, 4690.4, 4706, 4707, 4711.5, 4711.7, 4712.7, 5328.35, 5586, 5587, 11265.9, 14016.55, 14100.8, and 14100.9 to, to add Article 4.5 (commencing with Section 14145) to Chapter 7 of Part 3 of Division 9 of, to add and repeal Sections 14093.88 and 16809.45 of, to repeal Sections 14005.82, 14005.83, and 14016.11 of, and to repeal and add Sections 4710.9, 14005.30, and 14005.81 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 18, 1998. Filed with
Secretary of State August 19, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2780, Gallegos. Health services: Budget Act implementation.

Existing law permits certain state agencies to make advance payments to community-based nonprofit agencies with which they have contracted, in accordance with certain limitations.

This bill would add to those agencies permitted to make these advance payments, the State Department of Developmental Services.

Existing law provides for the State Department of Developmental Services to serve as the lead agency responsible for administration and coordination of the statewide system of services for the enhancement of the development of children who have disabilities or who are at risk of having disabilities and to minimize the potential

for delays in their development under the California Early Intervention Services Act.

This bill would revise the responsibilities of the State Department of Developmental Services under this program.

Existing law provides for the provision of services to persons with developmental disabilities by regional centers pursuant to contracts with the State Department of Developmental Services.

This bill would revise procedures for ensuring regional center compliance with contracts with the State Department of Developmental Services.

The bill would also revise regional center staffing requirements and procedures for screening those children.

Existing law requires the State Department of Developmental Services to contract for clients' rights advocacy services with contractors meeting specified requirements.

This bill would permit the State Department of Developmental Services to contract with the Organization of Area Boards for the purpose of providing clients' rights advocacy services for persons with developmental disabilities who reside in developmental centers and state hospitals.

Existing law requires the Director of Developmental Services, within 30 days after the end of each calendar quarter, to publish a report of the financial status of all regional centers and their operations.

This bill would, instead, require this report to be published by December 31 of each year, and would require the report to contain, at a minimum, specified information.

Existing law requires the State Department of Developmental Services to adopt reimbursement rates for residential services purchased by regional centers.

Existing law also provides, pursuant to an Alternative Residential Model (ARM), that the State Department of Developmental Services establish separate reimbursement rates for residential services to persons with developmental disabilities residing in community care facilities, in accordance with specified requirements.

Existing law also requires the department to establish reimbursement rates, in accordance with specified requirements, for regional center services obtained from community-based day programs.

This bill would enact specified rate increase requirements for residential facility and community-based day program services.

The bill would enact competency training and testing requirements that must be met by direct care staff of these facilities.

Existing law permits regional centers to purchase in-home respite services in order to obtain specified services for a client living in his

or her own home. The Director of Developmental Services is required to establish reimbursement rates for these services.

This bill would require, for the 1998–99 fiscal year, that reimbursement rates for these services be increased based on the amount appropriated for this purpose in the Budget Act of 1998, with the amount of this rate increase to be used for increased reimbursement to in-home respite care services workers.

This bill would establish procedures for fair hearings regarding services provided for individuals with developmental disabilities.

This bill would authorize the implementation of a mediation procedure as an alternative to the fair hearing process, and would authorize parties to the proceeding to accept any decision arrived at pursuant to the mediation procedure or to request a fair hearing, if the party is not satisfied with the decision reached through the mediation process.

The bill would authorize the Director of Health Services or his or her representative to make decisions through the mediation process with respect to services provided through the federal medicaid program.

Existing law requires that before a health care practitioner who has ultimate authority over the care or primary diagnosis of a patient may deliver health care via telemedicine, the practitioner shall obtain verbal and written informed consent from the patient or the patient's legal representative.

This bill would revise elements of the definition of telemedicine.

Existing law requires that the Health and Welfare Agency establish an interdepartmental Task Force on Rural Health, to coordinate rural health policy development and program operations and to develop a strategic plan for rural health. The task force is required to be composed, at a minimum, of specified state officials.

This bill would add the Executive Director of the Managed Risk Medical Insurance Board to those required to be on the task force.

Existing law requires, until July 1, 1998, the Rural Health Policy Council, through the Office of Statewide Health Planning and Development, to develop and administer a program of grants for projects located in rural areas.

This bill would extend this grant program until July 1, 1999, and would add the Managed Risk Medical Insurance Board to the list of entities eligible for grants under the program.

Existing law requires this council to promote a strong working relationship between designated entities and other offices of rural health and to develop health initiatives and maximize the use of existing resources without duplicating effort.

This bill would require the council to adopt an annual workplan to describe how the office shall meet specific, measurable performance objectives designed to improve access to and the quality of health

care in rural areas. The bill would require the office to provide to the Legislature designated annual reports.

Existing law creates a health program under the jurisdiction of the State Department of Health Services for seasonal agricultural and migratory workers.

This bill would establish, in the department, the Seasonal Agricultural and Migratory Workers Advisory Committee, to be composed as specified, in order to advise the department on the level of resources, priorities, criteria, and guidelines necessary to implement this program.

Existing law provides for the licensure and regulation of health facilities, including acute care hospitals.

This bill would require that all general acute care hospitals subject to licensing shall maintain a medical records system that meets certain standards.

Existing law requires the State Department of Health Services, prior to the initial licensure or renewal of any person or persons to operate or manage an intermediate care facility/developmentally disabled habilitative, to secure from an appropriate law enforcement agency a criminal record to determine whether the applicant, facility administrator or manager, any direct care staff, or any other adult living in the same location, has ever been convicted of a crime other than a minor traffic violation.

This bill would also apply this requirement when a facility hires any direct care staff. It would also apply this requirement to an intermediate care facility/developmentally disabled nursing and an intermediate care facility/developmentally disabled, other than a state operated intermediate care facility/developmentally disabled.

Existing law also requires that if it is found that the applicant, facility administrator or manager, any direct care staff, or any other adult living in the same location, has been convicted of a crime, other than a minor traffic violation, the application or reapplication shall be denied, unless otherwise approved in accordance with existing law.

This bill would modify the grounds for licensure denial under these provisions.

Since violation of health facility licensure provisions is a crime, this bill would, by creating a new crime, constitute a state-mandated local program.

Existing law provides for various housing programs.

This bill would enact the California Statewide Supportive Housing Initiative Act, to be administered by the State Department of Mental Health, with the advice of the Supportive Housing Program Council which would be created by the bill. Under this program, the State Department of Mental Health would award grants to local public or private nonprofit agencies for housing and support services to low-income individuals with special needs.



Existing law sets forth procedures under which a local health department, as defined, may qualify for state financial assistance. Under these provisions, allocations, including a basic allotment, are made to administrative bodies of qualifying local health departments in a specified manner.

This bill would modify these provisions to refer to local health jurisdictions, as defined, rather than local health departments and would change the formula used to make basic allotments.

The bill would expand, commencing with the 1998–99 fiscal year, the purposes for which funds under these provisions may be appropriated to include supplementing existing levels of services related to communicable disease control activities and community and public health surveillance activities.

Existing law permits the State Department of Health Services and a county with a population of less than 40,000 to enter into a contract under which the department will operate a local public health service in the county.

This bill would increase the population of a county to which this authority would apply to a county with a population of less than 50,000.

Existing law, effective until January 1, 1999, permits any county that would have been eligible, as of January 1, 1988, to enter into a contract with the State Department of Health Services for the operation of a local public health service, to remain eligible to enter into such a contract notwithstanding an increase in population in excess of 40,000.

This bill would indefinitely extend this provision, and would apply this to an eligible county notwithstanding an increase in total population beyond the 50,000 limit.

Existing law, effective until January 1, 1999, requires that a fee, in addition to other fees, of up to \$2, be imposed on certified copies of birth or death records, marriage records, and marital dissolution records, for allocation to specified accounts for modernization and improvement of public record systems and collection of the data.

This bill would extend these provisions until January 1, 2002.

Existing law establishes the Comprehensive Perinatal Outreach Program, under which a county may contract with the State Department of Health Services to provide perinatal program coordination, patient advocacy, and expanded access services for, among others, low-income and postpartum women.

This bill would provide that funds appropriated for purposes of this program for a fiscal year shall be available for expenditure without regard to fiscal year.

Existing law requires the State Department of Health Services, pursuant to the California Children’s Services Program to administer a system to screen infants at high risk for deafness and a system to provide followup and assessment services, where necessary.



This bill would require the department to establish the Newborn and Infant Hearing Screening, Tracking, and Intervention Act.

The bill would specify the duties of the department under this program and would make conforming changes to link this program with the California Children's Services Program.

Existing law requires the State Department of Health Services to establish a genetic disease unit to coordinate all programs of the department in the area of genetic disease and provides procedures for the adoption of regulations for these purposes deemed to be an emergency.

This bill would delete the provisions related to emergency regulations for purposes of those provisions.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health services to eligible children. Coverage is required to be affordable using a purchasing pool model, issuance of insurance purchasing credits, or other appropriate means, and to be provided by a broad range of health plans, including insurers, health care service plans, county organized health systems, health care authorities, and local initiatives, including medical, dental, and vision services.

Existing law provides for eligibility of persons older than 12 months, and less than 19 years of age, who meet other criteria, including having a gross annual household income equal to or less than 200% of the federal poverty level and meeting citizenship and immigration requirements under the Healthy Families Program.

Existing law continuously appropriates money from the Healthy Families Fund for the purposes of implementation of the Healthy Families Program.

Existing law requires the State Department of Health Services to make use of the federal option to provide for one month of Medi-Cal eligibility at no share of cost for any child under 19 years of age who is found to be ineligible to receive Medi-Cal benefits without a share of cost upon a redetermination of eligibility.

This bill would repeal the requirement that the State Department of Health Services provide for the extended eligibility of children who, upon redetermination of eligibility, have been determined not to be eligible for Medi-Cal benefits without a share of cost, and would establish the Healthy Families Bridge Benefits Program, to provide for a month of eligibility for children who, after having been eligible for Medi-Cal benefits at no share of cost has been redetermined to be eligible for Medi-Cal benefits subject to a share of cost requirement and whose family income does not exceed 200% of the federal poverty level and who meets other requirements, and would provide for the administration of the program by the Managed Risk Medical Insurance Board. The bill would require that the month of eligibility benefits shall only be made available through a Medi-Cal provider or



under a Medi-Cal managed care arrangement or contract. The bill would specify that the program shall be funded by federal financial participation, and, by applying continuously appropriated money from the Healthy Families Fund for the purposes of the Healthy Families Bridge Benefits Program, this bill would result in an appropriation.

Existing law requires various reports in connection with the Healthy Families Program.

The bill would also require the Department of Alcohol and Drug Programs, in cooperation with the board, to review needs and collect data concerning adolescent alcohol and drug treatment and would require the board to collect and analyze related data.

Existing law requires the State Department of Health Services, in conjunction with the board, to conduct an outreach and education campaign relative to the Medi-Cal program and the Healthy Families Program.

This bill would require the plan to be submitted to the Legislature annually, and would require it to address certain issues. The bill would also authorize the department, in conjunction with the board, to conduct pilot outreach and education projects.

Existing law provides for the provision of mental health services to eligible individuals through state hospitals under the authority of the State Department of Mental Health.

This bill would require the State Department of Mental Health to develop policies and procedures at each state hospital to notify Members of the Legislature who represent the area in which the hospital is located, local law enforcement and designated local government entities in the event of a patient escape or walkaway.

Existing law provides that the State Department of Mental Health has jurisdiction over Metropolitan State Hospital, near the City of Norwalk in Los Angeles County.

This bill would require the Metropolitan State Hospital to, at a minimum, collect data on the use of medications, and restraint and seclusion, including the number and duration of restraint and seclusion incidents, in the youth program, and to provide the information to the Deputy Director of Long Term Care Services of the State Department of Mental Health and the appropriate policy committees and the fiscal committees of the Legislature, on a quarterly basis.

This bill would require that the Metropolitan State Hospital Youth Program's admission policy to require the referring agency to document all placement attempts prior to admission and to document all attempts to place a child during the discharge planning process.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.



Existing law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families.

Under existing law, CalWORKs recipients are eligible for Medi-Cal benefits. In addition, certain CalWORKs recipients whose aid is discontinued are eligible to receive Medi-Cal benefits for a limited transitional period.

This bill would, effective October 1, 1998, provide for an additional 12-month period of eligibility for transitional Medi-Cal benefits.

This bill would require that whenever aid to an individual or family is discontinued under the CalWORKs program for any reason other than fraud, the State Department of Social Services shall include, in the notice of termination of aid, a brief summary of the requirements for obtaining this transitional Medi-Cal coverage, as well as a form that the individual or family may fill out and return to request transitional Medi-Cal benefits.

Existing law requires the State Department of Health Services to extend eligibility for health care services pursuant to the Medi-Cal program to all recipients of aid under the CalWORKs program, to the extent federal participation is available, and authorizes the department to adopt emergency regulations to implement these provisions.

This bill would recast these provisions to require, to the extent federal financial participation is available, that Medi-Cal benefits be provided to individuals eligible for services under designated federal law and that the department exercise its options under federal law to adopt less restrictive income and resource eligibility standards and methodologies to allow all recipients under the CalWORKs program to be eligible for Medi-Cal benefits. The bill would require the department to expand eligibility for Medi-Cal through specified activities and would apply this provision retroactively to January 1, 1998.

Existing law provides procedures under which a Medi-Cal beneficiary, as a condition of coverage for Medi-Cal benefits, obtains benefits by receiving a monthly Medi-Cal card, which may be used to obtain services from individual providers, or by enrolling in a prepaid managed care health plan, pilot program, or fee-for-service case management provider.

This bill would require that whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of eligibility shall also result in the recipient's or beneficiary's disenrollment from Medi-Cal managed care health or dental plans, if enrolled. The bill would also require, operative 12 months after the effective date of this bill, that



whenever the State Department of Health Services or the county welfare department processes a change in a public assistance recipient's or Medi-Cal beneficiary's residence or aid code that will result in the recipient's or beneficiary's disenrollment from the managed care health or dental plan in which they are currently enrolled, a written notice shall be given to the recipient or beneficiary.

This bill would require the department, in any county in which certain conditions exist, to conduct a one-time survey aimed at determining why Medi-Cal beneficiaries fail to enroll in managed care plans. It would require the department to submit the survey results to the appropriate policy and budget committees of the Legislature, and to implement a plan of correction.

This bill would establish in the State Treasury the Local Initiative Traditional Provider Loan Assistance Account to be continuously appropriated to the department to establish a pilot project to provide collateral to guarantee loans to traditional providers who serve large numbers of Medi-Cal recipients and who are under contract with the L.A. Care Health Plan to serve Medi-Cal recipients.

Existing law requires any Medi-Cal provider of durable medical equipment or incontinence supplies to provide a bond of not less than \$25,000 to the State Department of Health Services.

This bill would revise that requirement to apply to providers of incontinence supplies and medical supplies, and would impose specific bond requirements for providers of durable medical equipment and providers of home health agency services as a condition of participation in the Medi-Cal program.

Existing law, until January 1, 1999, provides for the provision of drugs that are reimbursed through the Medi-Cal program without prior authorization when they are on an approved list of contract drugs.

This bill would extend until January 1, 2000 provisions for the use of a list of contract drugs for purposes of the Medi-Cal program.

Existing law, until January 1, 1999, authorizes the State Department of Health Services to enter into contracts with manufacturers of single-source and multiple-source drugs under the Medi-Cal program, and specifies procedures for the implementation of that authority.

This bill would extend that authority to January 1, 2000.

Existing law authorizes the Director of Health Services, as well as the Attorney General, and other specified officials, to bring an action to recover the reasonable value of benefits provided or that will be provided to a Medi-Cal recipient against a 3rd party, including an insurance carrier, because of any injury for which the 3rd party is liable.

Existing law contains procedures governing these actions, as well as provisions pertaining to the director's right to claim



reimbursement when the claim against a 3rd party is brought by another person, including the recipient.

This bill would define the term reasonable value of benefits. It would also provide for the use of this term in provisions relating to the director's right to reimbursement in an action brought by the recipient.

Existing law authorizes local governmental agencies to participate in the Administrative Claiming process for the administration of claiming funds under the Medi-Cal program.

This bill would include local educational consortia, as defined, among those entities permitted to participate in the Administrative Claiming process, through which each local educational consortium would be required to contract with the State Department of Health Services to participate in the Administrative Claiming process as a condition of participation in the Medi-Cal program. A local educational consortium would be responsible for the local educational agencies in its service region. The bill would require each local educational consortium to perform administrative and training functions for local educational agencies.

Existing law requires that each local governmental agency participating in the Medi-Cal Administrative Claiming program or the Targeted Case Management program to contribute to the State Department of Health Services a portion of the local agency's local fund that has been made available due to those programs.

This bill would limit that requirement to claims approved for the 1994–95 to 1997–98 fiscal years, inclusive.

Existing law, until January 1, 2001, authorizes the provision of health care services under the Medi-Cal Program through telemedicine.

This bill would establish minimum standards for audio and visual telemedicine systems used for that purpose, and would require the department to report to the appropriate committees of the Legislature by January 1, 2000, on the application of telemedicine to provide various types of care.

Under existing law, the State Department of Health Services is required to implement a pilot program for the establishment of pilot project sites around the state, for the purpose of providing long-term care to elderly and disabled adults.

This bill would pursuant to specified findings and declarations, authorize the department, beginning with the 1998–99 fiscal year, contingent on appropriation of funds by the Budget Act, to contract with a nonprofit entity incorporated in California to serve as the center for long-term care integration, which would facilitate the development of community-based local organizing groups (LOGs), through a public-private partnership. The bill would specify the responsibilities of the department and the center in this regard. The bill would also require the department to administer grants to LOGs



for purposes of implementing long-term care pilot projects, for the planning phase of the project, the development phase, or both, in accordance with specified criteria.

Under existing law, the Medi-Cal program provides for a special methodology of reimbursement of disproportionate share hospitals for the provision of inpatient hospital services. Existing law generally defines a disproportionate share hospital as a hospital that has proportionately higher costs, volume, or services related to the provision of services to Medi-Cal or other low-income patients than the statewide average.

Under the Medi-Cal program, the department is required to make supplemental payments to certain disproportionate share hospitals based on specified criteria. Payments are made from defined intergovernmental transfers that are paid into the Medi-Cal Inpatient Payment Adjustment Fund, as required, with this fund being continuously appropriated for specified purposes. Existing law authorizes moneys in the fund to be used for transfers to the Health Care Deposit Fund, a continuously appropriated fund, in the amount of \$154,757,690 for the 1997-98 fiscal year and each fiscal year thereafter.

This bill would authorize, instead, transfers to the Health Care Deposit Fund in the amount of \$114,757,690 for the 1998-99 fiscal year and each fiscal year thereafter. By changing the amount of moneys transferred for purposes of the continuously appropriated Health Care Deposit Fund from the continuously appropriated Inpatient Payment Adjustment Fund, the bill would result in an appropriation.

Existing law provides for the County Medical Services Program Governing Board and requires the board to carry out various duties relating to the provision of health services at the county level.

This bill would authorize the board to contract with the State Department of Health Services for interfund transfers and the joint or shared use of the fiscal intermediary to provide for the operation of the Healthy Families Program and the Children's Treatment Program. This authorization would expire on June 30, 1999.

Existing law permits local education agencies to obtain Medi-Cal reimbursement for certain health care services.

This bill would appropriate \$2,600,000 from the Proposition 98 Reversion Fund to a consortium of county offices of education, on a one-time basis, for 3-year grants, beginning with the 1998-99 fiscal year, for the purpose of supporting technical assistance and focused group training to teach school district personnel how to maximize reimbursements of federal funds for Medi-Cal services and case management. It would also create a technical advisory committee for this purpose.

This bill would authorize the State Department of Health Services to adopt emergency regulations to implement provisions of the bill.



The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) (1) For the purposes of this section, “telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine” for purposes of this section.

(2) For purposes of this section, “interactive” means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, “health care practitioner” has the same meaning as “licentiate” as defined in paragraph (2) of subdivision (a) of Section 805.

(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient’s legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient’s legal representative verbally and in writing:

(1) The patient or the patient’s legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient’s legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

SEC. 2. Section 11019 of the Government Code is amended to read:

11019. (a) Any department or authority specified in subdivision (b) may, upon determining that an advance payment is essential for the effective implementation of a program within the provisions of this section, and to the extent funds are available, advance to a community-based private nonprofit agency with which it has contracted, pursuant to federal law and related state law, for the delivery of services, not to exceed 25 percent of the annual allocation to be made pursuant to the contract and those laws, during the fiscal year to the private nonprofit agency. Advances in excess of 25

percent may be made on contracts financed by a federal program when the advances are not prohibited by federal guidelines. Advance payments may be provided for services to be performed under any contract with a total annual contract amount of four hundred thousand dollars (\$400,000) or less. This amount shall be increased by 5 percent, as determined by the Department of Finance, for each year commencing with 1989. Advance payments may also be made with respect to any contract which the Department of Finance determines has been entered into with any community-based private nonprofit agency with modest reserves and potential cash-flow problems. No advance payment shall be granted if the total annual contract exceeds four hundred thousand dollars (\$400,000), without the prior approval of the Department of Finance.

The specific departments and authority mentioned in subdivision (b) shall develop a plan to establish control procedures for advance payments. Each plan shall include a procedure whereby the department or authority determines whether or not an advance payment is essential for the effective implementation of a particular program being funded. Each plan is required to be approved by the Department of Finance.

(b) Subdivision (a) shall apply to the Emergency Medical Service Authority, the California Department of Aging, the State Department of Developmental Services, the State Department of Alcohol and Drug Programs, the Department of Corrections, the Department of Economic Opportunity, the Employment Development Department, the State Department of Health Services, the State Department of Mental Health, the Department of Rehabilitation, the State Department of Social Services, the Department of the Youth Authority, the State Department of Education, the area boards on developmental disabilities, the Organization of Area Boards, the Office of Statewide Health Planning and Development, and the California Environmental Protection Agency, including all boards and departments contained therein.

Subdivision (a) shall also apply to the Health and Welfare Agency which may make advance payments, pursuant to the requirements of that subdivision, to multipurpose senior services projects as established in Sections 9400 to 9413, inclusive, of the Welfare and Institutions Code.

(c) A county may, upon determining that an advance payment is essential for the effective implementation of a program within the provisions of this section, and to the extent funds are available, and not more frequently than once each fiscal year, advance to a community-based private nonprofit agency with which it has contracted, pursuant to any applicable federal or state law, for the delivery of services, not to exceed 25 percent of the annual allocation



to be made pursuant to the contract and those laws, during the fiscal year to the private nonprofit agency.

SEC. 3. Section 95001 of the Government Code is amended to read:

95001. (a) The Legislature hereby finds and declares all of the following:

(1) There is a need to provide appropriate early intervention services individually designed for infants and toddlers from birth through two years of age, who have disabilities or are at risk of having disabilities, to enhance their development and to minimize the potential for developmental delays.

(2) Early intervention services for infants and toddlers with disabilities or at risk represent an investment of resources, in that these services reduce the ultimate costs to our society, by minimizing the need for special education and related services in later school years and by minimizing the likelihood of institutionalization. These services also maximize the ability of families to better provide for the special needs of their child. Early intervention services for infants and toddlers with disabilities maximize the potential to be effective in the context of daily life and activities, including the potential to live independently, and exercise the full rights of citizenship. The earlier intervention is started, the greater is the ultimate cost-effectiveness and the higher is the educational attainment and quality of life achieved by children with disabilities.

(3) The family is the constant in the child's life, while the service system and personnel within those systems fluctuate. Because the primary responsibility of an infant or toddler's well-being rests with the family, services should support and enhance the family's capability to meet the special developmental needs of their infant or toddler with disabilities.

(4) Family to family support strengthens families' ability to fully participate in services planning and their capacity to care for their infant or toddler with disabilities.

(5) Meeting the complex needs of infants with disabilities and their families requires active state and local coordinated, collaborative and accessible service delivery systems that are flexible, culturally competent and responsive to family identified needs. When health, developmental, educational and social programs are coordinated, they are proven to be cost-effective, not only for systems, but for families as well.

(6) Family-professional collaboration contributes to changing the ways that early intervention services are provided and to enhancing their effectiveness.

(7) Infants and toddlers with disabilities are a part of their communities, and as citizens make valuable contributions to society as a whole.

(b) Therefore, it is the intent of the Legislature that:

(1) Funding provided under Part H of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1471 et seq.), be used to improve and enhance early intervention services as defined in this title by developing innovative ways of providing family focused, coordinated services, which are built upon existing systems.

(2) The State Department of Developmental Services, the California Department of Education, the State Department of Health Services, the State Department of Mental Health, the State Department of Social Services, and the State Department of Alcohol and Drug Programs coordinate services to infants and toddlers with disabilities and their families. These agencies need to collaborate with families and communities to provide a family-centered, comprehensive, multidisciplinary, interagency community-based, early intervention system for infants and toddlers with disabilities.

(3) Families be well informed, supported, and respected as capable and collaborative decisionmakers regarding services for their child.

(4) Professionals be supported to enhance their training and maintain a high level of expertise in their field, as well as knowledge of what constitutes most effective early intervention practices.

(5) Families and professionals join in collaborative partnerships to develop early intervention services which meet the needs of infants and toddlers with disabilities, and that such partnerships be the basis for the development of services which meet the needs of the culturally and linguistically diverse population of California.

(6) To the maximum extent possible, infants and toddlers with disabilities and their families be provided services in the most natural environment, and include the use of natural supports and existing community resources.

(7) The services delivery system be responsive to the families and children it serves within the context of cooperation and coordination among the various agencies.

(8) Early intervention program quality be assured and maintained through established early intervention program and personnel standards.

(9) The early intervention system be responsive to public input and participation in the development of implementation policies and procedures for early intervention services through the forum of an interagency coordinating council established pursuant to federal regulations under Part H of the Individuals with Disabilities Education Act.

(c) It is not the intent of the Legislature to require the State Department of Education to implement this title unless adequate reimbursement, as specified and agreed to by the department, is provided to the department from federal funds from Part H of the Individuals with Disabilities Education Act.



SEC. 4. Section 95007 of the Government Code is amended to read:

95007. The State Department of Developmental Services shall serve as the lead agency responsible for administration and coordination of the statewide system. The specific duties and responsibilities of the State Department of Developmental Services shall include, but are not limited to, all of the following:

(a) Establishing a single point of contact with the federal Office of Special Education Programs for the administration of Part H of the Individuals with Disabilities Education Act.

(b) Administering the state early intervention system in accordance with Part H of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1471 et seq.), and applicable regulations and approved state application.

(c) Administering mandatory and discretionary components as specified in Sections 95022 and 95024.

(d) Administering fiscal arrangements and interagency agreements with participating agencies and community-based organizations to implement this title.

(e) Establishing interagency procedures, including the designation of local coordinating structures, as are necessary to share agency information and to coordinate policymaking activities.

(f) Adopting written procedures for receiving and resolving complaints regarding violations of Part H of the Individuals with Disabilities Education Act by public agencies covered under this title, as specified in Section 1476(b)(9) of Title 20 of the United States Code and appropriate federal regulations.

(g) Establishing, adopting, and implementing procedural safeguards that comply with the requirements of Part H of the Individuals with Disabilities Education Act, as specified in Section 1480 of Title 20 of the United States Code and appropriate federal regulations.

(h) (1) Monitoring of agencies, institutions, and organizations receiving assistance under this title.

(2) Monitoring shall be conducted by interagency teams that are sufficiently trained to ensure compliance. Interagency teams shall consist of, but not be limited to, representatives from the State Department of Developmental Services, the State Department of Education, the interagency coordinating council, or a local family resource center or network parent, direct service provider, or any other agency responsible for providing early intervention services.

(3) All members of an interagency team shall have access to all information that is subject to review. Members of each interagency team shall maintain the confidentiality of the information, and each member of the interagency team shall sign a written agreement of confidentiality.

(4) A summary of monitoring issues and findings shall be forwarded biannually to the interagency coordinating council for review.

(i) Establishing innovative approaches to information distribution, family support services, and interagency coordination at the local level.

(j) Ensuring the provision of appropriate early intervention services to all infants eligible under Part H of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1471 et seq.) and under Section 95014, except for those infants who have solely a low incidence disability as defined in Section 56026.5 of the Education Code and who are not eligible for services under the Lanterman Development Disabilities Services Act (Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code).

The development and implementation of subdivisions (e) to (h), inclusive, shall be a collaborative effort between the State Department of Developmental Services and the State Department of Education. In establishing the written procedures for receiving and resolving complaints as specified in subdivision (f) and in establishing and implementing procedural safeguards as specified in subdivision (g), it is the intent of the Legislature that these procedures be identical for all infants served under this act and shall be in accordance with Section 303.400 and subdivision (b) of Section 303.420 of Title 34 of the Code of Federal Regulations. The procedural safeguards and due process requirements established under this title shall replace and be used in lieu of due process procedures contained in Chapter 1 (commencing with Section 4500) of Division 4.5 of the Welfare and Institutions Code and Part 30 (commencing with Section 56500) of the Education Code for infants and their families eligible under this title.

SEC. 5. Section 95012 of the Government Code is amended to read:

95012. (a) The following departments shall cooperate and coordinate their early intervention services for eligible infants and their families under this title, and need to collaborate with families and communities, to provide a family-centered, comprehensive, multidisciplinary, interagency, community-based early intervention system:

- (1) State Department of Developmental Services.
- (2) State Department of Education.
- (3) State Department of Health Services.
- (4) State Department of Social Services.
- (5) State Department of Mental Health.
- (6) State Department of Alcohol and Drug Programs.

(b) Each participating department shall enter into an interagency agreement with the State Department of Developmental Services. Each interagency agreement shall specify, at a minimum, the



agency's current and continuing level of financial participation in providing services to infants and toddlers with disabilities and their families. Each interagency agreement shall also specify procedures for resolving disputes in a timely manner. Interagency agreements shall also contain provisions for ensuring effective cooperation and coordination among agencies concerning policymaking activities associated with the implementation of this title, including legislative proposals, regulation development, and fiscal planning. All interagency agreements shall be reviewed annually and revised as necessary.

SEC. 6. Section 95016 of the Government Code is amended to read:

95016. (a) Each infant or toddler referred for evaluation for early intervention services shall have a timely, comprehensive, multidisciplinary evaluation of his or her needs and level of functioning in order to determine eligibility. In the process of determining eligibility of an infant or toddler, an assessment shall be conducted by qualified personnel, and shall include a family interview, to identify the child's unique strengths and needs and the services appropriate to meet those needs; and the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler. Evaluations and assessments shall be shared and utilized between the regional center and the local education agency, and any other agency providing services for the eligible infant or toddler, as appropriate. Family assessments shall be family directed and voluntary on the part of the family. Families shall be afforded the opportunity to participate in all decisions regarding eligibility and services.

(b) Regional centers and local education agencies or their designees shall be responsible for ensuring that the requirements of this section are implemented. The procedures, requirements, and timelines for evaluation and assessment shall be consistent with the statutes and regulations under Part H of the Individuals with Disabilities Education Act (20 U.S.C. 1471 et seq.), applicable regulations, and this title, and shall be specified in regulations adopted pursuant to Section 95028.

SEC. 7. Section 95018 of the Government Code is amended to read:

95018. Each eligible infant or toddler and family shall be provided a service coordinator who will be responsible for facilitating the implementation of the individualized family service plan and for coordinating with other agencies and persons providing services to the family. The qualifications, responsibilities, and functions of service coordinators shall be consistent with the statutes and regulations under Part H and this title, and shall be specified in regulations adopted pursuant to Section 95028. The State

Department of Developmental Services shall ensure that service coordinators, as defined in federal law, meet federal and state regulation requirements, are trained to work with infants and their families, and meet competency requirements set forth in subsection (d) of Section 303.22 of Title 34 of the Code of Federal Regulations. Service coordinator caseloads shall be an overall average of 62 consumers to each staff member. Pursuant to Section 303.521 of Title 34 of the Code of Federal Regulations, service coordination is not subject to any fees that might be established for any other federal or state program.

SEC. 8. Section 95020 of the Government Code is amended to read:

95020. (a) Each eligible infant or toddler shall have an individualized family service plan. The individualized family service plan shall be used in place of an individualized program plan required pursuant to Sections 4646 and 4646.5 of the Welfare and Institutions Code, the individual education plan required pursuant to Section 56340 of the Education Code, or any other applicable service plan.

(b) For an infant or toddler who has been evaluated for the first time, a meeting to share the results of the evaluation, to determine eligibility and, for children who are eligible, to develop the initial individualized family service plan shall be conducted within 45 calendar days of receipt of the written referral. Evaluation results and determination of eligibility may be shared in a meeting with the family prior to the individualized family service plan. Written parent consent to evaluate and assess shall be obtained within the 45-day timeline. A regional center, local education agency, or their designees shall initiate and conduct this meeting. Families shall be afforded the opportunity to participate in all decisions regarding eligibility and services.

(c) Parents shall be fully informed of their rights, including the right to invite any other person, including a family member or an advocate or peer parent, or any or all of them, to accompany them to any or all individualized family service plan meetings. With parental consent, a referral shall be made to the local family resource center or network.

(d) The individualized family service plan shall be in writing and shall address all of the following:

(1) A statement of the infant or toddler's present levels of physical development including vision, hearing, and health status, cognitive development, communication development, social and emotional development, and adaptive developments.

(2) With the concurrence of the family, a statement of the family's concerns, priorities, and resources related to meeting the special developmental needs of the eligible infant or toddler.



(3) A statement of the major outcomes expected to be achieved for the infant or toddler and family where services for the family are related to meeting the special developmental needs of the eligible infant or toddler.

(4) The criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions are necessary.

(5) A statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler as identified in paragraph (3), including, but not limited to, the frequency, intensity, location, duration, and method of delivering the services, and ways of providing services in natural environments.

(6) A statement of the agency responsible for providing the identified services.

(7) The name of the service coordinator who shall be responsible for facilitating implementation of the plan and coordinating with other agencies and persons.

(8) The steps to be taken to ensure transition of the infant or toddler upon reaching three years of age to other appropriate services. These may include, as appropriate, special education or other services offered in natural environments.

(9) The projected dates for the initiation of services in paragraph (5) and the anticipated duration of those services.

(e) Each service identified on the individualized family service plan shall be designated as one of three types:

(1) An early intervention service, as defined in Part H (20 U.S.C. Section 1472 (2)), and applicable regulations, that is provided or purchased through the regional center, local education agency, or other participating agency. The State Department of Health Services, State Department of Social Services, State Department of Mental Health, and State Department of Alcohol and Drug Programs shall provide services in accordance with state and federal law and applicable regulations, and up to the level of funding as appropriated by the Legislature. Early intervention services identified on an individualized family service plan that exceed the funding, statutory, and regulatory requirements of these departments shall be provided or purchased by regional centers or local education agencies under subdivisions (b) and (c) of Section 95014. The State Department of Health Services, State Department of Social Services, State Department of Mental Health, and State Department of Alcohol and Drug Programs shall not be required to provide early intervention services over their existing funding, statutory, and regulatory requirements.

(2) Any other service, other than those specified in paragraph (1), which the eligible infant or toddler or his or her family may receive from other state programs, subject to the eligibility standards of those programs.



(3) A referral to a nonrequired service that may be provided to an eligible infant or toddler or his or her family. Nonrequired services are those services that are not defined as early intervention services or do not relate to meeting the special developmental needs of an eligible infant or toddler related to the disability, but which may be helpful to the family. The granting or denial of nonrequired services by any public or private agency is not subject to appeal under this title.

(f) An annual review, and other periodic reviews of the individualized family service plan for an infant's or toddler and the infant or toddler's family shall be conducted to determine the degree of progress that is being made in achieving the outcomes specified in the plan and whether modification or revision of the outcomes or services is necessary. The frequency, participants, purpose, and required processes for annual and periodic reviews shall be consistent with the statutes and regulations under Part H and this title, and shall be specified in regulations adopted pursuant to Section 95028.

SEC. 9. Section 1179.2 of the Health and Safety Code is amended to read:

1179.2. (a) The Health and Welfare Agency shall establish an interdepartmental Task Force on Rural Health to coordinate rural health policy development and program operations and to develop a strategic plan for rural health.

(b) At a minimum, the following state departmental directors, or their representatives, shall participate on this task force:

(1) The Director of Health Services.

(2) The Director of Statewide Health Planning and Development.

(3) The Director of Alcohol and Drug Programs.

(4) The Director of the Emergency Medical Services Authority.

(5) The Director of Mental Health.

(6) The Executive Director of the Managed Risk Medical Insurance Board.

(c) The task force shall review and direct the activities of the Office of Rural Health or the alternative organizational structure, as determined by the Secretary of the Health and Welfare Agency.

(d) The task force shall establish appropriate mechanisms, such as ad hoc or standing advisory committees or the holding of public hearings in rural communities for the purpose of soliciting and receiving input from these communities, including input from rural hospitals, rural clinics, health care service plans, local governments, academia, and consumers.

(e) By May 1, 1996, the Secretary of the Health and Welfare Agency shall report to the Chair of the Joint Legislative Budget Committee and the Chairs of the Senate and Assembly Health Committees, and at that time submit the strategic plan developed by

the task force. This strategic plan may include but shall not be limited to the following elements:

- (1) The status of establishing an Office of Rural Health or alternative organizational structure.
- (2) The roles and responsibilities of that office or alternative organizational structure.
- (3) The mechanism for ongoing input to the office or alternative organizational structure by members of the public, rural health care providers, rural hospitals, health care service plans, and local governments.
- (4) The identification of all departments and agencies with significant program or funding responsibility for rural health care.
- (5) A detailed plan to consolidate and coordinate the activities of the programs identified pursuant to paragraph (4) to better meet the health care needs of rural residents.

SEC. 10. Section 1179.3 of the Health and Safety Code is amended to read:

1179.3. (a) (1) The Rural Health Policy Council shall develop and administer a competitive grants program for projects located in rural areas of California.

(2) The Rural Health Policy Council shall define “rural area” for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.

(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.

(4) The Rural Health Policy Council shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.

(5) The Office of Statewide Health Planning and Development shall administer the funds appropriated by the Budget Act of 1998 for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the departments represented on the Rural Health Policy Council, which include the State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health Services, the State Department of Mental Health, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service.

(b) The Rural Health Policy Council shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The Office of Statewide Health Planning and Development shall periodically report to the Rural Health Policy Council on the status of the funded projects. This information shall also be available at the public meetings.

(d) This section shall become inoperative on July 1, 1999, and, as of January 1, 2000, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2000, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 11. Section 1179.5 is added to the Health and Safety Code, to read:

1179.5. (a) The Rural Health Policy Office within the Office of Statewide Health Planning and Development serving as staff to the Rural Health Policy Council shall develop an annual workplan which is adopted by the council. The workplan shall describe how the council shall meet specific, measurable performance objectives. The workplan shall be designed to further the goals of the Rural Health Policy Council to improve access to, and the quality of, health care in rural areas.

(b) The workplan required under subdivision (a) shall include information on how the council intends to address, at a minimum, all of the following topics:

(1) Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.

(2) Network delivery and integrated delivery systems.

(3) Streamlining the regulatory process.

(4) Assessing the impact of managed care in rural communities.

(5) Reviewing and proposing changes necessary to improve current funding issues.

(6) Increasing the use of technology.

(7) Supporting innovative efforts to improve patient transportation.

(8) Providing strategic planning for local communities.

(9) Improving communication between the state and rural providers.

(10) Increasing workforce availability in rural areas.

(c) The Rural Health Policy Council shall provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved by the office during the

preceding 12 months and what changes it will incorporate into the workplan for the following year. The first report pursuant to this section shall be provided to the Legislature by February 1, 1999.

SEC. 12. Section 1250.05 is added to the Health and Safety Code, to read:

1250.05. (a) All general acute care hospitals licensed under this chapter shall maintain a medical records system, based upon current standards for medical record retrieval and storage, that organizes all medical records for each patient under a unique identifier.

(b) This section shall not require electronic records or require that all portions of patients' records be stored in a single location.

(c) In addition, all general acute care hospitals shall have the ability to identify the location of all portions of a patient's medical record that are maintained under the general acute care hospital's license.

(d) All general acute care hospitals, including those holding a consolidated general acute care license pursuant to Section 1250.8, shall develop and implement policies and procedures to ensure that relevant portions of patients' medical records can be made available within a reasonable period of time to respond to the request of a treating physician, other authorized medical professionals, authorized representatives of the department, or any other person authorized by law to make such a request, taking into consideration the physical location of the records and hours of operation of the facility where those records are located, as well as the best interests of the patients.

SEC. 13. Section 1265.5 of the Health and Safety Code is amended to read:

1265.5. (a) Prior to the initial licensure or renewal of a license of any person or persons to operate or manage an intermediate care facility/developmentally disabled habilitative, intermediate care facility/developmentally disabled nursing, or intermediate care facility/developmentally disabled, other than a state-operated intermediate care facility/developmentally disabled, or upon hiring any direct care staff, the state department shall secure from an appropriate law enforcement agency a criminal record to determine whether the applicant, facility administrator or manager, any direct care staff, or any other adult living in the same location, has ever been convicted of a crime other than a minor traffic violation. Nothing in this section shall be construed to require a criminal record check of a person receiving services in an intermediate care facility/developmentally disabled habilitative, intermediate care facility/developmentally disabled nursing, or intermediate care facility/developmentally disabled.

(b) Subject to subdivision (c), the application for licensure or renewal shall be denied if the criminal record indicates that any person described in subdivision (a) has been convicted of a violation

or attempted violation of any one or more of the following Penal Code provisions: Section 187, subdivision (a) of Section 192, Section 203, 205, 206, 207, 209, 210, 210.5, 211, 220, 222, 243.4, 245, 261, 262, or 264.1, Sections 265 to 267, inclusive, Section 273a, 273d, 273.5, or 285, subdivisions (c), (d), (f), and (g) of Section 286, Section 288, subdivisions (c), (d), (f), and (g) of Section 288a, Section 288.5, 289, 289.5, 368, 451, 459, 470, 475, 484, or 484b, Sections 484d to 484j, inclusive, Section 487, 488, 496, 503, 518, or 666.

(c) An application shall not be denied pursuant to subdivision (b), if any of the following applies:

(1) The person was convicted of a felony and has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of the Penal Code and the information or accusation against him or her has been dismissed pursuant to Section 1203.4 of the Penal Code.

(2) The person was convicted of a misdemeanor and the information or accusation against him or her has been dismissed pursuant to Section 1203.4 or 1203.4a of the Penal Code.

(3) The person was convicted of a felony or a misdemeanor, but has previously disclosed the fact of each conviction to the department, and the department has made a determination in accordance with law that the conviction does not disqualify the person.

(4) The application for licensure or renewal shall also be denied if the criminal record of the person includes a conviction in another state for an offense that, if committed or attempted in this state, would have been punishable as one or more of the offenses set forth in subdivision (b), unless evidence of rehabilitation comparable to the certificate of rehabilitation or dismissal of a misdemeanor as set forth in paragraph (1) or (2) of subdivision (b) is provided to the department.

(d) If the criminal record indicates any conviction other than a minor traffic violation or a conviction listed in subdivision (b), the department shall deny the application for licensure or renewal, unless it determines that the person has been rehabilitated, after consideration of the following factors:

(1) The nature and the seriousness of the crime under consideration.

(2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(3) The time which has elapsed since commission of the crime or conduct referred to in paragraph (1) or (2).

(4) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant.

(5) Any rehabilitation evidence submitted by the person.

(e) For purposes of this section, “direct care staff” means all facility staff who are trained and experienced in the care of persons with developmental disabilities and who directly provide program and nursing services to clients. Administrative and licensed personnel shall be considered direct care staff when directly providing program and nursing services to clients.

(f) Upon employment of any person specified in subdivision (a), prior to any contact with patients or residents, the facility shall submit fingerprint cards to the department for the purpose of obtaining a criminal record check.

(g) Within five working days of the receipt of the criminal record or information from the Department of Justice, the department shall notify the licensee or applicant of any criminal convictions.

SEC. 14. Chapter 4 (commencing with Section 53250) is added to Part 4 of Division 31 of the Health and Safety Code, to read:

CHAPTER 4. CALIFORNIA STATEWIDE SUPPORTIVE HOUSING
INITIATIVE ACT

53250. The Legislature finds and declares all of the following:

(a) Decent, affordable housing is an essential human need that relates directly to families and persons achieving self-sufficiency and maximizing their independence.

(b) The presence of homeless persons on our streets and the existence of unsafe, unsanitary housing constitute conditions that increase public health and safety problems.

(c) At least 150,000 people are homeless in California, and studies indicate that at least one-half are disabled with mental illness, medical problems, other health conditions, or other special needs.

(d) Very low income people with disabilities cycle through costly, short-term crisis programs, such as hospital emergency rooms, psychiatric hospitalization, emergency shelters, and jails, and fail to make a long-term transition to stability and permanent housing.

(e) Evidence from around the country shows that a significant percentage of those who are trying to move from welfare to work face substantial barriers, including mental health and other health-related disabilities.

(f) Supportive housing, which blends affordable housing with necessary support and employment services, has been shown to be effective in stabilizing tenants so that they regain a stake in the community.

(g) Supportive housing has been shown to decrease by 50 percent the use of emergency medical services and incarceration, reduce recidivism among substance abusers by more than 50 percent, increase employment rates by 100 percent, and successfully retain tenants at rates exceeding 80 percent.



(h) Supportive housing has previously been developed and operated primarily with local government, federal government, philanthropic, and private sector support.

(i) Supportive housing is currently available to only one or two of every 10 Californians who could benefit from it.

(j) By establishing a supportive housing initiative, the state can leverage substantial local, federal, and private support, reduce costs, and ensure that existing supportive housing programs are sustained and that new supportive housing programs are developed.

(k) It is further the intent of the Legislature in enacting this chapter to encourage local communities to enter into partnerships that expand and strengthen supportive housing opportunities for very low income Californians with disabilities such as mental illness, HIV and AIDS, chemical dependency, and other chronic health conditions, or individuals eligible for services provided under the Lanterman Developmental Disabilities Services Act.

(l) It is the intent of the Legislature that state funds provide the incentive and leverage for local governments, the nonprofit sector, and the private sector to invest resources that expand and strengthen supportive housing opportunities.

(m) It is further the intent of the Legislature that local communities, in their applications for state funding, will identify, based upon a local assessment of need, both of the following:

(1) The specific characteristics of those among the target population that will live in the supportive housing.

(2) The types of supportive housing arrangements that are most appropriate.

(n) It is further the intent of the Legislature that funding provided for the Statewide Supportive Housing Initiative shall be used for the array of groups identified in the target population, as defined in subdivision (d) of Section 53260.

53255. This chapter shall be known and may be cited as the California Statewide Supportive Housing Initiative Act.

53260. For the purposes of this chapter, the following definitions apply:

(a) “Council” means the Supportive Housing Program Council.

(b) “Lead agency” means the State Department of Mental Health, which shall be the governmental agency that is primarily responsible for administering this chapter.

(c) “Supportive housing” means housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the tenant to retain the housing, improve his or her health status, maximize their ability to live and, when possible, to work in the community. This housing may include apartments, single-room occupancy residences, or single-family homes.

(d) “Target population” means adults with low incomes having one or more disabilities, including mental illness, HIV or AIDS, substance abuse, or other chronic health conditions, or individuals eligible for services provided under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code) and may, among other populations, include families with children, elderly persons, young adults aging out of the foster care system, individuals exiting from institutional settings, or homeless people.

53265. (a) In order to encourage the integration of housing and services, it is the intent of the Legislature to promote interagency coordination and collaboration among not only local private and public agencies, but also among the state agencies responsible for the provision of housing and support services to very low income Californians.

(b) Therefore there is hereby established the Supportive Housing Program Council to assist with the implementation of this chapter.

(c) Members of the council shall include all of the following:

(1) The following state officials or their designees.

(A) The Secretary of the Health and Welfare Agency.

(B) The Secretary of the Business, Transportation and Housing Agency.

(C) The directors of the State Department of Mental Health, the State Department of Developmental Services, the State Department of Social Services, the State Department of Health Services, the California Department of Aging, the Department of Housing and Community Development, the State Department of Alcohol and Drug Programs, the California Housing Finance Agency, the Department of Rehabilitation, and the Department of Employment Development.

(2) Three consumer representatives from the target population, appointed by the Secretary of the Health and Welfare Agency, shall also serve on the council.

(d) The duties of the council shall include all of the following:

(1) Developing, promoting, and implementing policy supporting this chapter.

(2) Assisting the lead agency in reviewing the requests for grant applications, reviewing grant applications submitted to the lead agency, and providing the lead agency with recommendations for awarding grants pursuant to Section 53275.

(3) Reviewing input regarding program policy and direction from individuals and entities with experience with the target population.

(4) Assisting the lead agency to coordinate programs under this chapter with special needs housing programs offered by government or private lenders.

(5) Assisting the lead agency in fulfilling its responsibilities under this chapter.

(6) Providing recommendations to the lead agency regarding this chapter.

(7) At the request of the lead agency, assisting agencies in planning and implementing this chapter including assisting with local technical assistance.

53270. The department shall award grants to local government or private nonprofit agencies for services to the target population in accordance with this chapter.

53275. (a) Grants shall be awarded by the lead agency based upon the recommendations of the council and pursuant to this chapter. The lead agency shall issue requests for applications for awarding the grants, which shall specify maximum dollar amounts for which grants may be awarded. The request for applications also shall specify other criteria, as required by this chapter. Applicants may apply for a single supportive housing project, or may submit a single application for several projects.

(b) The lead agency shall award grants as follows:

(1) Grants shall be awarded for up to a three-year period. Each award shall be in an amount not to exceed four hundred fifty thousand dollars (\$450,000) for a single project, or one million dollars (\$1,000,000) for an application from a single jurisdiction for several projects at the discretion of the lead agency, in consultation with the council. At the discretion of the lead agency, these grants may include up to twenty-five thousand dollars (\$25,000) for one-time startup grants which may be used, among other things, for purchasing equipment or furniture, hiring staff, designing a program evaluation, or hiring a consultant.

(2) All grants awarded under this subdivision shall be matched by the grantee with fifty cents (\$0.50) for each one dollar (\$1) awarded in the first year, one dollar (\$1) for each one dollar (\$1) awarded in the second year, and one dollar and fifty cents (\$1.50) for each one dollar (\$1) awarded in the third year. The match shall be contributed in cash or as services or resources of comparable value. It is the intent of the Legislature that participants seek and utilize private funds, or public funds administered by the federal or local governments for this purpose.

(3) In order to receive a grant under this chapter, an applicant shall demonstrate a need for supportive housing for low-income individuals with special needs and a local commitment to providing funding for the purpose of developing and operating supportive housing.

(c) A local nonprofit agency or local government agency shall be eligible for a grant under this chapter if it demonstrates in its program plan that it:

(1) Meets local priorities for supportive housing as identified in a publicly adopted planning document, such as the Consolidated Plan prepared for the Department of Housing and Urban Development,

the Continuum of Care Plan, or a local plan for housing services for the target population.

(2) Provides evidence that affordable housing linked to services appropriate to the target population will be made available.

(3) Has established collaborative agreements with housing and service programs to deliver the necessary services and housing to the target population.

(4) Requests funding supplements and does not supplant existing funding.

53280. The lead agency shall give preference to proposals that do any of the following:

(a) Provide supportive housing to underserved target groups for which few alternative resources are available.

(b) Demonstrate collaborative agreements between entities that fund and provide local public and private housing services.

(c) Demonstrate cost avoidance as compared to other housing and service or institutional options available to the specific target population.

(d) Propose to serve the target population with an average income of not more than 100 percent of the federal poverty guidelines, or higher at the discretion of the council.

(e) Demonstrate the capacity and readiness to begin operation of a supportive housing program within one year of receiving the grant.

53285. (a) Each local nonprofit agency, local government agency, or group of agencies seeking a grant under this chapter shall submit an application to the lead agency at a time and manner, and with appropriate information, as the lead agency may reasonably require.

(b) Each application shall include all of the following:

(1) A description of the proposed supportive housing, including the target population or populations to be served, the type of housing and its location, and the services to be provided. If the application includes funding for housing services, a detailed description of how the funds will be used for operating or leasing subsidies.

(2) Documentation of the need for the supportive housing.

(3) A description of the objectives of the supportive housing, the amount and sources of required funding, the existing resources to be used or redirected, the priorities for development and timing of the supportive housing program, and the procedure for evaluation, including specific targets and outcome measures, provisions for data collection and recordkeeping, and the proposed results or outcomes of the supportive housing.

(4) Information on the track record and financial status of the agencies providing the services and the housing.

(5) A description of technical assistance needs, if any.

(6) A plan for continuing to carry out the supportive housing program at the end of the three-year funding period.

53290. For purposes of this chapter, support services include, but are not limited to:

- (a) Health care services including immunizations, vision and hearing tests and services, dental services, physical examinations, diagnostic and referral services, prenatal care, and nutrition services.
- (b) Mental health services including, but not limited to, crisis intervention, assessments, and referrals.
- (c) Substance abuse prevention and treatment services.
- (d) Family support and parenting education.
- (e) Vocational, educational, and employment services, including tutoring, mentoring, internships, training, and job placement.
- (f) Counseling.
- (g) Case management services.
- (h) Payments for housing costs, including payments for leasing costs or the operating costs of supportive housing as proposed by the applicant.
- (i) The costs of evaluation.
- (j) Other services that benefit the target population.

53295. A grantee may contract with other entities to provide the services described in Section 53290 to support housing residents.

53300. No more than 10 percent of the amount appropriated in a fiscal year for the purposes of this chapter may be used for state administration of this chapter, including evaluation and technical assistance. Technical assistance shall include, but is not limited to, assisting with collaborations, providing information, and convening training workshops. The Legislature shall be notified of the administrative costs of this program pursuant to Section 28 of the Budget Act.

53305. (a) The lead agency shall ensure that adequate resources are available to conduct an evaluation. The lead agency shall ensure that an evaluation of this chapter is conducted and completed as follows:

(1) An interim evaluation shall be completed and submitted to the Legislature at the end of the first 18 months in which grants are first awarded.

(2) A final evaluation shall be completed and submitted to the Legislature within nine months of the end of the three-year grant period.

(b) The evaluation shall be based upon the outcomes and methodologies for measuring success in achieving each proposed outcome identified by grantees, and shall, at a minimum, include outcomes related to cost avoidance, housing stability, quality of services, and the health status of tenants.

(c) The lead agency or its designee shall provide technical assistance to local jurisdictions in designing and completing the evaluation, including identification of a methodology for collecting

the necessary information, and assistance with obtaining that information from state agencies to the extent necessary.

(d) The lead agency or its designee shall compile the information on outcomes from all grantees into a single interim evaluation, and a single final evaluation.

SEC. 15. It is the intent of the Legislature that, in conjunction with a proposal to enhance funding for an emerging infectious disease program at the state level, that the Legislature seek to enhance and strengthen the capability of local health jurisdictions to form a state-local system to control communicable disease and to closely monitor the health status of the state's population.

SEC. 16. Section 100171 of the Health and Safety Code is amended to read:

100171. Notwithstanding any other provision of law, whenever the department is authorized or required by statute, regulation, due process (Fourteenth Amendment, United States Constitution; subdivision (a) of Section 7 of Article I, California Constitution), or a contract, to conduct an adjudicative hearing leading to a final decision of the director or the department, the following shall apply:

(a) The proceeding shall be conducted pursuant to the administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except as specified in this section.

(b) Notwithstanding Section 11502 of the Government Code, whenever the department conducts a hearing under Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the hearing shall be conducted before an administrative law judge selected by the department and assigned to a hearing office that complies with the procedural requirements of Chapter 4.5 (commencing with Section 11400) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Notwithstanding Section 11508 of the Government Code, whenever the department conducts a hearing under Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the time and place of the hearing shall be determined by the staff assigned to the hearing office of the department, unless the department by regulation specifies otherwise.

(d) (1) The following sections of the Government Code shall apply to any adjudicative hearing conducted by the department only if the department has not, by regulation, specified an alternative procedure for the particular type of hearing at issue: Section 11503 (relating to accusations), Section 11504 (relating to statements of issues), Section 11505 (relating to the contents of the statement to respondent), Section 11506 (relating to the notice of defense),

Section 11507.6 (relating to discovery rights and procedures), Section 11508 (relating to the time and place of hearings), and Section 11516 (relating to amendment of accusations).

(2) Any alternative procedure specified by the department in accordance with this subdivision shall conform to the purpose of the Government Code provision it replaces insofar as it is possible to do so consistent with the specific procedural requirements applicable to the type of hearing at issue.

(3) Any alternative procedures adopted by the department under this subdivision shall not diminish the amount of notice given of the issues to be heard by the department or deprive appellants of the right to discovery suitable to the particular proceedings. Modifications of timeframes or of the place of hearing made by regulation may not lengthen timeframes within which the department is required to act nor require hearings to be held at a greater distance from the appellant's place of residence or business than is the case under the otherwise applicable Government Code provision.

(e) The specific timelines specified in Section 11517 of the Government Code shall not apply to any adjudicative hearing conducted by the department to the extent that the department has, by regulation, specified different timelines for the particular type of hearing at issue.

(f) In the case of any adjudicative hearing conducted by the department, "transcript," as used in subdivision (c) of Section 11517 of the Government Code, shall be deemed to include any alternative form of recordation of the oral proceedings, including, but not limited to, an audiotape.

(g) Pursuant to Section 11415.50 of the Government Code, the department may, by regulation, provide for any appropriate informal procedure to be used for an informal level of review that does not itself lead to a final decision of the department or the director. The procedures specified in Article 10 (commencing with Section 11445.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code shall not apply to any such an informal level of review.

(h) Notwithstanding any other provision of law, any adjudicative hearing conducted by the department that is conducted pursuant to a federal statutory or regulatory requirement that contains specific procedures may be conducted pursuant to those procedures to the extent they are inconsistent with the procedures specified in this section.

(i) Nothing in this section shall apply to a fair hearing involving a Medi-Cal beneficiary insofar as the hearing is, by agreement or otherwise, heard before an administrative law judge employed by the State Department of Social Services, or insofar as the hearing is being held pursuant to Division 4.5 (commencing with Section 4500)

of the Welfare and Institutions Code in connection with services provided by the State Department of Developmental Services under applicable federal medicaid waivers. Nothing in this subdivision shall be interpreted as abrogating the authority of the State Department of Health Services as the single state agency under the state medicaid plan.

(j) Nothing in this provision shall supersede express provisions of law that apply to any hearing that is not adjudicative in nature or that does not involve due process rights specific to an individual or specific individuals, as opposed to the general public or a segment of the general public.

SEC. 17. Section 101230 of the Health and Safety Code is amended to read:

101230. From the appropriation made for the purposes of this article, allocation shall be made to the administrative bodies of qualifying local health jurisdictions described as public health administrative organizations in Section 101185 in the following manner:

(a) A basic allotment as follows:

To the administrative bodies of local health jurisdictions a basic allotment of fifty thousand dollars (\$50,000) per local health jurisdiction or twenty-one and seven-tenths cents (\$0.2171048900) per capita, whichever is greater. The population estimates used for the calculation of the per capita allotment shall be based on the Department of Finance's E-1 Report, "City/County Population Estimates with Annual Percentage Changes" as of January 1 of the previous fiscal year. However, if within a county there are one or more city health jurisdictions, the county shall subtract the population of the city or cities from the county total population for purposes of calculating the per capita total. If the amounts appropriated are insufficient to fully fund the allocations specified in this subdivision, the State Department of Health Services shall prorate and adjust each local health jurisdiction's allocation using the same percentage that each local health jurisdiction's allocation represents to the total appropriation under the allocation methodology specified in this subdivision.

(b) A per capita allotment, determined as follows:

After deducting the amounts allowed for the basic allotment as provided in subdivision (a), the balance of the appropriation, if any, shall be allotted on a per capita basis to the administrative body of each local health jurisdiction in the proportion that the population of that local health jurisdiction bears to the population of all qualified local health jurisdictions of the state.

(c) Beginning in the fiscal year 1998–99, funds appropriated for the purposes of this article shall be used to supplement existing levels of the services described in paragraphs (1) and (2) of subdivision (d) provided by qualifying participating local health jurisdictions. As part



of a county's or city's annual realignment trust fund report to the Controller, a participating county or city shall annually certify to the Controller that it has deposited county or city funds equal to or exceeding the amount described in subdivisions (a) and (b) of Section 17608.10. The county or city shall not be required to submit any additional reports or modifications to existing reports to document compliance with this subdivision. Funds shall be disbursed quarterly in advance to local health jurisdictions beginning July 1, 1998. If a county or city does not accept its allocation, any unallocated funds provided under this section shall be redistributed according to subdivision (b) to the participating counties and cities that remain.

(d) Funds shall be used for the following:

(1) Communicable disease control activities. Communicable disease control activities shall include, but not be limited to, communicable disease prevention, epidemiologic services, public health laboratory identification, surveillance, immunizations, follow-up care for sexually transmitted disease and tuberculosis control, and support services.

(2) Community and public health surveillance activities. These activities shall include, but not be limited to, epidemiological analyses, and monitoring and investigating communicable diseases and illnesses due to other untoward health events.

(e) Funds shall not be used for medical services, including jail medical treatment, except as provided in subdivision (d).

SEC. 18. Section 101300 of the Health and Safety Code is amended to read:

101300. (a) (1) The board of supervisors of a county with a population of less than 50,000 may enter into a contract with the department and the department may enter into a contract with that county to organize and operate a local public health service in that county.

(2) The department may conduct the local public health service either directly, or by contract with other agencies, or by some combination of these methods as agreed upon by the department and the board of supervisors of the county concerned.

(3) The board of supervisors may create a county board of public health or similar local advisory group.

(b) Any county proposing to contract with the department pursuant to this section in the 1992–93 fiscal year and each fiscal year thereafter shall submit to the department a notice of intent to contract adopted by the board of supervisors no later than March 1 of the fiscal year preceding the fiscal year for which the agreement will be in effect in accordance with procedures established by the department. A county may withdraw this notice no later than May 1 of the fiscal year preceding the fiscal year for which the agreement will be in effect in accordance with procedures established by the department. If a county fails to withdraw its notice by this date, it

shall be responsible for any and all necessary costs incurred by the department in providing or preparing to provide public health services in that county.

(c) A county contracting with the department pursuant to this section shall not be relieved of its public health care obligation under Section 101025.

(d) (1) Any county contracting with the department pursuant to this section shall pay, by the 15th of each month, the agreed contract amount.

(2) If a county does not make the agreed monthly payment, the department may terminate the county's participation in the program.

(e) The counties and the department shall work collectively to ensure that expenditures do not exceed the funds available for the program in any fiscal year.

(f) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) The state shall not incur any liability except as specified in this section.

SEC. 19. Section 101305 of the Health and Safety Code is amended to read:

101305. Any counties that were eligible for organization and operation of local public health services by the department pursuant to former Section 1157, as amended by Section 130 of Chapter 429 of the Statutes of 1978, as of January 1, 1988, shall continue to be eligible, notwithstanding an increase in total population beyond the 50,000 population limit of that section.

SEC. 20. Section 103640 of the Health and Safety Code is amended to read:

103640. (a) In addition to the fees prescribed by subdivisions (a) to (d), inclusive, of Section 103625, all applicants for certified copies of the records described in those subdivisions shall pay an additional fee of up to two dollars (\$2), that shall be collected by the State Registrar, the local registrar, county recorder, or county clerk, as the case may be.

(b) Except as provided in paragraph (2), the local public official charged with the collection of the additional fee established pursuant to subdivision (a) may create a Vital and Health Statistics Trust Fund. The fees collected by local public officials pursuant to subdivision (a) shall be distributed as follows:

(1) Up to ninety cents (\$0.90) of each fee collected pursuant to this section shall be deposited with the State Registrar for deposit pursuant to Section 102250.

(2) The remainder of the fee collected pursuant to this section shall be deposited into the collecting agency's Vital and Health Statistics Trust Fund.

(3) Any local public official that does not establish a local Vital and Health Statistics Trust Fund shall forward the entire fee collected pursuant to this section to the State Registrar, who shall deposit the fees pursuant to Section 102250.

(4) Fees collected by the State Registrar shall be deposited pursuant to Section 102250.

(c) Moneys in each Vital and Health Statistics Trust Fund shall be available to the public official charged with the collection of fees pursuant to this section to defray the administrative costs of collecting and reporting with respect to those fees and for the other costs, as follows:

(1) Modernization of vital record operations, including improvement, automation, and technical support of vital record systems.

(2) Improvement in the collection and analysis of health-related birth and death certificate information, and other community health data collection and analysis, as appropriate.

(d) Funds collected pursuant to this section shall not be used to supplant existing funding that is necessary for the daily operation of vital record systems. It is the intent of the Legislature that funds collected pursuant to this section be used to enhance service to the public, to improve analytical capabilities of state and local health authorities in addressing the health needs of newborn children, maternal health problems, and to analyze the health status of the general population.

(e) Each county shall annually submit a report to the State Registrar by March 1, containing information on the amount of revenues collected pursuant to this section for the previous calendar year and on how the revenues were expended and for what purpose.

(f) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2002, deletes or extends that date.

(g) This section shall become operative on January 1, 1997.

SEC. 21. Section 104569 is added to the Health and Safety Code, to read:

104569. Funds appropriated for purposes of this program for a fiscal year shall be available for expenditure without regard to fiscal year.

SEC. 22. Section 123975 of the Health and Safety Code is amended to read:

123975. (a) The department, in consultation with selected representatives of participating neonatal intensive care units, shall establish a system to screen all newborns and infants for hearing loss as defined in subdivision (e) of Section 124116 and create and

maintain a system of assessment and followup services for newborns and infants identified by the screening in approved neonatal intensive care units participating in the California Children's Services Program. Screening, assessment and followup services and reporting of these services shall be provided in a manner consistent with Article 6.5 (commencing with Section 124115) of Chapter 3.

This section shall not be applicable to a newborn child whose parent or guardian objects to the tests on the ground that the tests conflict with his or her religious beliefs or practices.

(b) It is the intent of the Legislature, in enacting this section, to ensure the establishment and maintenance of protocols and quality of standards.

(c) The department shall implement this section for newborns and infants in neonatal intensive care units participating in the California Children's Services Program.

SEC. 23. Article 6.5 (commencing with Section 124115) is added to Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, to read:

Article 6.5. Newborn and Infant Hearing Screening, Tracking,
and Intervention Program

124115. This article shall be known, and may be cited as, the Newborn and Infant Hearing Screening, Tracking and Intervention Act.

124115.5. (a) The Legislature finds and declares all of the following:

(1) Hearing loss occurs in newborns more frequently than any other health condition for which newborn screening is currently required.

(2) Early detection of hearing loss, early intervention, and followup services before six months of age, have been demonstrated to be highly effective in facilitating the development of a child's health and communication and cognitive skills.

(3) The State of California supports the National Healthy People 2000 goals, which promote early identification of children with hearing loss.

(4) Children of all ages can receive reliable and valid screening for hearing loss in a cost-effective manner.

(5) Appropriate screening and identification of newborns and infants with hearing loss will facilitate early intervention during this critical time for development of communication, and may, therefore, serve the public purposes of promoting the healthy development of children and reducing public expenditure for health care and special education and related services.

(b) The purposes of this article shall be to do all of the following:

(1) Provide early detection of hearing loss in newborns, as soon after birth as possible, to enable children who fail a hearing screening and their families and other caregivers to obtain needed confirmatory tests or multidisciplinary evaluation, or both, and intervention services, at the earliest opportunity.

(2) Prevent or mitigate delays of language and communication development that could lead to academic failures associated with late identification of hearing loss.

(3) Provide the state with the information necessary to effectively plan, establish, and evaluate a comprehensive system of appropriate services for parents with newborns and infants who have a hearing loss.

124116. As used in this article:

(a) “Birth admission” means the time after birth that the newborn remains in the hospital nursery prior to discharge.

(b) “CCS” means the California Children’s Services program administered through the State Department of Health Services.

(c) “Department” means the State Department of Health Services.

(d) “Followup services” means all of the following:

(1) All services necessary to diagnose and confirm a hearing loss.

(2) Ongoing audiological services to monitor hearing.

(3) Communication services, including, but not limited to, aural rehabilitation, speech, language, social, and psychological services.

(4) Necessary support of the infant and family.

(e) “Hearing loss” means a hearing loss of 30 decibels or greater in the frequency region important for speech recognition and comprehension in one or both ears (from 500 through 4000 Hz). However, as technology allows for changes to this definition through the detection of less severe hearing loss, the department may modify this definition by regulation.

(f) “Infant” means a child 29 days through 12 months old.

(g) “Intervention services” means the early intervention services described in Part C of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1475 et seq.).

(h) “Newborn” means a child less than 29 days old.

(i) “Newborn hearing screening services” means those hearing screening tests that are necessary to achieve the identification of all newborns and infants with a hearing loss.

(j) “Parent” means a natural parent, adoptive parent, or legal guardian of a child.

124116.5. (a) (1) Every CCS-approved general acute care hospital with licensed perinatal services in this state shall offer all parents of a newborn, upon birth admission, a hearing screening test for the identification of hearing loss, using protocols approved by the department or its designee. The department shall begin phasing in implementation of a comprehensive hearing screening program by

CCS-approved general acute care hospitals with licensed perinatal services on or after July 1, 1999, and a 100 percent participation shall be achieved by December 31, 2002.

(2) In order to meet the department's certification criteria, a hospital shall be responsible for developing a screening program that provides competent hearing screening, utilizes appropriate staff and equipment for administering the testing, completes the testing prior to the newborn's discharge from a newborn nursery unit, refers infants with abnormal screening results, maintains and reports data as required by the department, and provides physician and family-parent education.

(b) A hearing screening test provided for pursuant to subdivision (a) shall be performed by a licensed physician, licensed registered nurse, licensed audiologist, or an appropriately trained individual who is supervised in the performance of the test by a licensed health care professional.

124117. The department or its designee shall approve hospitals for participation as newborn hearing screening providers. These facilities shall then receive payment from the department for the newborn hearing screening services provided to newborns and infants eligible for the Medi-Cal or CCS programs in accordance with this article.

124118. The department or its designee shall provide every CCS-approved acute care hospital that has licensed perinatal services or a CCS-approved neonatal intensive care unit (NICU), or both, as specified in Section 123975, written information on the current and most effective means available to screen the hearing of newborns and infants, and shall provide technical assistance and consultation to these hospitals in developing a system of screening each newborn and infant receiving care at the facility. The information shall also include the mechanism for referral of newborns and infants with abnormal test results.

124118.5. (a) The department shall establish a system of early hearing detection and intervention centers that shall provide technical assistance and consultation to hospitals in the startup and ongoing implementation of a facility screening program and followup system.

(b) The early hearing detection and intervention centers shall be chosen by the department according to standards and criteria developed by the California Children's Services Program (CCS). Each center shall be responsible for a separate geographic catchment area as determined by the program.

(c) Each center shall be required to develop a system that shall provide outreach and education to hospitals in its catchment area, approve hospitals on behalf of the department for participation as newborn hearing screening providers, maintain a data base of all newborns and infants screened in the catchment area, ensure

appropriate follow up for newborns and infants with an abnormal screen including diagnostic evaluation and referral to intervention service programs if the newborn or infant is found to have a hearing loss, and provide coordination with the CCS and local early intervention programs as defined in Title 14 (commencing with Section 95000) of the Government Code.

124119. (a) The department shall develop and implement a reporting and tracking system for newborns and infants tested for hearing loss.

(b) The system shall provide the department with information and data to effectively plan, establish, monitor, and evaluate the Newborn and Infant Hearing Screening, Tracking and Intervention Program, including the screening and followup components, as well as the comprehensive system of services for newborns and infants who are deaf or hard-of-hearing and their families.

(c) Every CCS-approved acute care hospital with licensed perinatal services or CCS-approved NICU, or both, in this state shall report to the department or the department's designee information as specified by the department to be included in the department's reporting and tracking system.

(d) All providers of audiological follow up and diagnostic services provided under this article shall report to the department or the department's designee information as specified by the department to be included in the department's reporting and tracking system.

(e) The information compiled and maintained in the tracking system shall be kept confidential in accordance with Chapter 5 (commencing with Section 10850) of Part 1 of Division 9 of the Welfare and Institutions Code, the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code), and the applicable requirements and provisions of Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1475 et seq.).

(f) Data collected by the tracking system obtained directly from the medical records of the newborn or infant shall be for the confidential use of the department and for the persons or public or private entities that the department determines are necessary to carry out the intent of the reporting and tracking system.

(g) A health facility, clinical laboratory, audiologist, physician, registered nurse, or any other officer or employee of a health facility or laboratory or employee of an audiologist or physician, shall not be criminally or civilly liable for furnishing information to the department or its designee pursuant to the requirements of this section.

124119.5. Parents of all newborns and infants diagnosed with a hearing loss shall be provided written information on the availability of community resources and services for children with hearing loss, including those provided in accordance with the federal Individuals

with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), through the reporting and tracking system followup procedures. Information shall include listings of local and statewide nonprofit deaf and hard-of-hearing consumer-based organizations, parent support organizations affiliated with deafness, and programs offered through the State Department of Social Services, Office of Deaf Access, State Department of Developmental Services, and the State Department of Education.

124120. The department shall conduct a community outreach and awareness campaign to inform medical providers, pregnant women, and the families of newborns and infants on the availability of the newborn hearing screening program and the value of early hearing testing. The outreach and awareness campaign shall be conducted by an independent contractor.

124120.5. A newborn hearing screening test shall not be performed without the written consent of the parent.

SEC. 24. Section 124560 is added to the Health and Safety Code, to read:

124560. (a) The Seasonal Agricultural and Migratory Workers Advisory Committee is hereby established in the State Department of Health Services.

(b) The committee shall advise the department on the level of resources, priorities, criteria, and guidelines necessary to implement this chapter pertaining to the health of seasonal and migratory agricultural workers.

(c) The committee shall be composed of 11 members, appointed by the Director of Health Services, who are knowledgeable concerning the health care needs of seasonal and migratory farm workers and their families. Committee members shall serve two-year terms. Two members shall be nominated by the Speaker of the Assembly, and two by the Senate Committee on Rules. The members of the committee shall be selected from the following categories of persons:

(1) Seasonal and migratory farm workers and their families.

(2) Health care providers from nonprofit community health centers that have a documented history of serving seasonal and migratory agricultural workers.

(3) Health care professionals.

(4) Private citizens with documented experience in serving the seasonal agricultural and migratory worker population.

SEC. 25. Section 125000 of the Health and Safety Code is amended to read:

125000. (a) It is the policy of the State of California to make every effort to detect, as early as possible, phenylketonuria and other preventable heritable or congenital disorders leading to mental retardation or physical defects.

The department shall establish a genetic disease unit, that shall coordinate all programs of the department in the area of genetic disease. The unit shall promote a statewide program of information, testing, and counseling services and shall have the responsibility of designating tests and regulations to be used in executing this program.

The information, tests, and counseling for children shall be in accordance with accepted medical practices and shall be administered to each child born in California once the department has established appropriate regulations and testing methods. The information, tests, and counseling for pregnant women shall be in accordance with accepted medical practices and shall be offered to each pregnant woman in California once the department has established appropriate regulations and testing methods. These regulations shall follow the standards and principles specified in Section 124980. The department may provide laboratory testing facilities or contract with any laboratory that it deems qualified to conduct tests required under this section. However, notwithstanding Section 125005, provision of laboratory testing facilities by the department shall be contingent upon the provision of funding therefor by specific appropriation to the Genetic Disease Testing Fund enacted by the Legislature. If moneys appropriated for purposes of this section are not authorized for expenditure to provide laboratory facilities, the department may nevertheless contract to provide laboratory testing services pursuant to this section and shall perform laboratory services, including, but not limited to, quality control, confirmatory, and emergency testing, necessary to ensure the objectives of this program.

(b) The department shall charge a fee for any tests performed pursuant to this section. The amount of the fee shall be established and periodically adjusted by the director in order to meet the costs of this section.

(c) The department shall inform all hospitals or physicians and surgeons, or both, of required regulations and tests and may alter or withdraw any of these requirements whenever sound medical practice so indicates.

(d) This section shall not apply if a parent or guardian of the newborn child objects to a test on the ground that the test conflicts with his or her religious beliefs or practices.

(e) The genetic disease unit is authorized to make grants or contracts or payments to vendors approved by the department for all of the following:

- (1) Testing and counseling services.
- (2) Demonstration projects to determine the desirability and feasibility of additional tests or new genetic services.
- (3) To initiate the development of genetic services in areas of need.



(4) To purchase or provide genetic services from any sums as are appropriated for this purpose.

(f) The genetic disease unit shall evaluate and prepare recommendations on the implementation of tests for the detection of hereditary and congenital diseases, including, but not limited to, cystic fibrosis and congenital adrenal hyperplasia. The genetic disease unit shall also evaluate and prepare recommendations on the availability and effectiveness of preventative followup interventions, including the use of specialized medically necessary dietary products.

It is the intent of the Legislature that funds for the support of the evaluations and recommendations required pursuant to this subdivision, and for the activities authorized pursuant to subdivision (e), shall be provided in the annual Budget Act appropriation from the Genetic Disease Testing Fund.

(g) Health care providers that contract with a prepaid group practice health care service plan that annually has at least 20,000 births among its membership, may provide, without contracting with the department, any or all of the testing and counseling services required to be provided under this section or the regulations adopted pursuant thereto, if the services meet the quality standards and adhere to the regulations established by the department and the plan pays that portion of a fee established under this section that is directly attributable to the department's cost of administering the testing or counseling service and to any required testing or counseling services provided by the state for plan members. The payment by the plan, as provided in this subdivision, shall be deemed to fulfill any obligation the provider or the provider's patient may have to the department to pay a fee in connection with the testing or counseling service.

(h) The department may appoint experts in the area of genetic screening, including, but not limited to, cytogenetics, molecular biology, prenatal, specimen collection, and ultrasound to provide expert advice and opinion on the interpretation and enforcement of regulations adopted pursuant to this section. These experts shall be designated agents of the state with respect to their assignments. These experts shall receive no salary, but shall be reimbursed for expenses associated with the purposes of this section. All expenses of the experts for the purposes of this section shall be paid from the Genetic Disease Testing Fund.

SEC. 26. Section 125070 of the Health and Safety Code is amended to read:

125070. Laboratories licensed by the department shall not offer the maternal serum-alpha fetoprotein screening test for prenatal detection of neural tube defects of the fetus until the department has developed regulations, under the authorization granted by Section 124980. However, laboratories providing this testing, as of July 21,

1983, may continue to provide this testing until these regulations become operative. The department shall adopt regulations pursuant to this section.

SEC. 27. Section 12693.95 of the Insurance Code is amended to read:

12693.95. (a) The board in consultation with the Department of Alcohol and Drug Programs shall provide the Legislature by April 15, 1998, a proposal assessing the viability of providing additional drug and alcohol treatment services for children enrolled in the program.

If the board determines that it is feasible to provide additional federal funds received pursuant to Title XXI (commencing with Section 2101) of the Social Security Act to counties to finance drug and alcohol services and required federal approval is obtained, the board shall negotiate with participating health plans to establish memoranda of understanding between plans and counties to facilitate referral of children in need of these services.

(b) Based on the April 15, 1998, report by the board to the Legislature, the Legislature finds and declares that there is a statewide gap in publicly funded alcohol and other drug treatment for adolescents which is significant and systemic.

(1) Therefore, the Department of Alcohol and Drug Programs, in cooperation with the board, shall do the following:

(A) Review capacity needs for the Healthy Families Program target group after year one data has been collected and an assessment of the adequacy of the benefit can be made.

(B) Request that counties provide data on the number of adolescents requesting alcohol and other drug treatment and whether they are participating in the Healthy Families Program.

(2) The board shall do the following:

(A) Request the participating health plans to voluntarily collect data, as prescribed by the board, on the number of children needing services that exceed the substance abuse benefit in their plan.

(B) Upon contract renewal, require participating health plans to collect and report the data.

(C) By September 1, 1999, provide the policy and fiscal committees of the Legislature with an analysis of the data obtained by the Department of Alcohol and Drug Programs and from the participating health plans.

SEC. 28. Chapter 16.1 (commencing with Section 12693.98) is added to Part 6.2 of Division 2 of the Insurance Code, to read:

CHAPTER 16.1. HEALTHY FAMILIES BRIDGE BENEFITS PROGRAM

12693.98. (a) (1) The Healthy Families Bridge Benefits Program is hereby established to provide any child who meets the criteria set forth in subdivision (b) with a one calendar-month period of health care benefits in order to provide the child with an

opportunity to apply for the Healthy Families Program established under Chapter 16 (commencing with Section 12693).

(2) The Healthy Families Bridge Benefits Program shall be administered by the board.

(b) (1) Any child who meets all of the following requirements shall be eligible for one calendar month of Healthy Families benefits funded by Title XXI of the Social Security Act, known as the State Children's Health Insurance Program:

(A) He or she has been receiving, but is no longer eligible for, full-scope Medi-Cal benefits without a share of cost.

(B) He or she is eligible for full-scope Medi-Cal benefits with a share of cost.

(C) He or she is under 19 years of age at the time he or she is no longer eligible for full-scope Medi-Cal benefits without a share of cost.

(D) He or she has family income at or below 200 percent of the federal poverty level.

(E) He or she is not otherwise excluded under the definition of targeted low-income child under subsections (b)(1)(B)(ii), (b)(1)(C), and (b)(2) of Section 2110 of the Social Security Act (42 U.S.C. Secs. 1397jj(b)(1)(B)(ii), 1397jj(b)(1)(C), and 1397jj(b)(2)).

(2) The one calendar month of benefits under this chapter shall begin on the first day of the month following the last day of the receipt of benefits without a share of cost.

(c) The income methodology for determining a child's family income, as required by paragraph (1) of subdivision (b) shall be the same methodology used in determining a child's eligibility for the full scope of Medi-Cal benefits.

(d) The one calendar month period of Healthy Families benefits provided under this chapter shall be identical to the scope of benefits that the child was receiving under the Medi-Cal program without a share of cost.

(e) The one calendar month period of Healthy Families benefits provided under this chapter shall only be made available through a Medi-Cal provider or under a Medi-Cal managed care arrangement or contract.

(f) Nothing in this section shall be construed to provide Healthy Families benefits for more than a one calendar-month period under any circumstances, including the failure to apply for benefits under the Healthy Families Program or the failure to be made aware of the availability of the Healthy Families Program, unless the circumstances described in subdivision (b) reoccur.

(g) (1) This section shall become operative on the first day of the second month following the effective date of this section, subject to paragraph (2).

(2) Under no circumstances shall this section become operative until, and shall be implemented only to the extent that, all necessary

federal approvals, including approval of any amendments to the State Child Health Plan have been sought and obtained and federal financial participation under the federal State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act, has been approved.

(h) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:

(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than one calendar month.

(i) For purposes of this chapter, "Medi-Cal" means the state health care program established pursuant to Chapter 14 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 29. Section 4433.5 is added to the Welfare and Institutions Code, to read:

4433.5. Notwithstanding Section 4433, the department may contract with the Organization of Area Boards for the purpose of providing clients' rights advocacy services to individuals with developmental disabilities who reside in developmental centers and state hospitals.

SEC. 30. Section 4434 of the Welfare and Institutions Code is amended to read:

4434. (a) Notwithstanding preexisting rights to enforce the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), it is the intent of the Legislature that the department ensure that the regional centers operate in compliance with federal and state law and regulation and provide services and supports to consumers in compliance with the principles and specifics of this division.

(b) The department shall take all necessary actions to support regional centers to successfully achieve compliance with this section and provide high quality services and supports to consumers and their families.

(c) The contract between the department and individual regional centers required by Chapter 5 (commencing with Section 4620) of Division 4.5 shall include a provision requiring each regional center to render services in accordance with applicable provisions of state laws and regulations. In the event that the department finds a regional center has violated this requirement, or whenever it appears that any regional center has engaged in or is about to engage in any act or practice constituting a violation of any provision of Division 4.5

(commencing with Section 4500) or any regulation adopted thereunder, the department shall promptly take the appropriate steps necessary to ensure compliance with the law, including actions authorized under Section 4632 or 4635. The department, as the director deems appropriate, may pursue other legal or equitable remedies for enforcement of the obligations of regional centers including, but not limited to, seeking specific performance of the contract between the department and the regional center or otherwise act to enforce compliance with Division 4.5 (commencing with Section 4500) or any regulation adopted thereunder.

(d) As part of its responsibility to monitor regional centers, the department shall collect and review printed materials issued by the regional centers, including, but not limited to, purchase of service policies and other policies and guidelines utilized by regional centers when determining the services needs of a consumer, instructions and training materials for regional center staff, board meeting agendas and minutes, and general policy and notifications provided to all providers and consumers and families. Within a reasonable period of time, the department shall review new or amended purchase-of-service policies prior to implementation by the regional center to ensure compliance with statute and regulation. The department shall take appropriate and necessary steps to prevent regional centers from utilizing a policy or guideline that violates any provision of Division 4.5 (commencing with Section 4500) or any regulation adopted thereunder.

SEC. 31. Section 4511 is added to the Welfare and Institutions Code, to read:

4511. (a) The Legislature finds and declares that meeting the needs and honoring the choices of persons with developmental disabilities and their families requires information, skills and coordination and collaboration between consumers, families, regional centers, advocates and service and support providers.

(b) The Legislature further finds and declares that innovative and ongoing training opportunities can enhance the information and skills necessary and foster improved coordination and cooperation between system participants.

(c) The department shall be responsible, subject to the availability of fiscal and personnel resources, for securing, providing, and coordinating training to assist consumers and their families, regional centers, and services and support providers in acquiring the skills, knowledge, and competencies to achieve the purposes of this division.

(d) This training may include health and safety issues; person-centered planning; consumer and family rights; building circles of support; training and review protocols for the use of psychotropic and other medications; crime prevention; life quality assessment and outcomes; maximizing inclusive opportunities in the



community; how to communicate effectively with consumers; and developing opportunities for decisionmaking.

(e) Whenever possible, the department shall utilize existing training tools and expertise.

(f) Each training module shall include an evaluation component.

(g) The department shall establish an advisory group, consisting of consumers, family members, regional centers, service providers, advocates and legislative representatives. The advisory group shall make recommendations for training subjects, review the design of training modules, and assess training outcomes.

SEC. 32. Section 4513 is added to the Welfare and Institutions Code, to read:

4513. (a) Whenever the department allocates funds to a regional center through a request for proposal process to implement special projects funded through the Budget Act, the department shall require that the regional center demonstrate community support for the proposal.

(b) In awarding funds to regional centers to implement such proposals, the department shall consider, among other indicators, the following:

(1) The demonstrated commitment of the regional center in establishing or expanding the service or support.

(2) The demonstrated ability of the regional center to implement the proposal.

(3) The success or failure of previous efforts to establish or expand the service or support.

(4) The need for the establishment or expansion of the service and support in the regional center catchment area as compared to other geographic areas.

(c) The department may require periodic progress reports from the regional center in implementing a proposal.

(d) The department shall ensure that each funded and implemented proposal be evaluated and that the evaluation process include the input of consumers, families, providers and advocates, as appropriate.

(e) The department shall make these evaluations available to the public, upon request.

(f) The department shall develop and implement strategies for fostering the duplication of successful projects.

SEC. 33. Section 4596.5 of the Welfare and Institutions Code is amended to read:

4596.5. (a) In order to remain informed about the quality of services in the area and protect the legal, civil, and service rights of persons with developmental disabilities pursuant to Section 4590, the Legislature finds that it is necessary to conduct life quality assessments with consumers served by the regional centers.

(b) It is the intent of the Legislature that life quality assessments described in this section be conducted by area boards, unless an independent evaluation of the life quality assessment process, that shall be completed by April 30, 1998, identifies compelling reasons why this function should not be conducted by area boards.

(c) By July 1, 1998, the department shall enter into an interagency agreement with the Organization of Area Boards, on behalf of the area boards, to conduct the life quality assessments described in this section.

(d) Consistent with the responsibilities described in this chapter, the area board, with the consent of the consumer and, when appropriate, a family member, shall conduct life quality assessments with consumers living in out-of-home placements, supported living arrangements, or independent living arrangements no less than once every three years or more frequently upon the request of a consumer, or, when appropriate, a family member. A regional center or the department shall annually provide the local area board with a list, including, but not limited to, the name, address, and telephone number of each consumer, and, when appropriate, a family member, the consumer's date of birth, and the consumer's case manager, for all consumers living in out-of-home placements, supported living arrangements, or independent living arrangements, in order to facilitate area board contact with consumers and, when appropriate, family members, for the purpose of conducting life quality assessments.

(e) The life quality assessments shall be conducted by utilizing the State Department of Developmental Services' Looking at Life Quality Handbook.

(f) The assessments shall be conducted by consumers, families, providers, and others, including volunteer surveyors. Each area board shall recruit, train, supervise, and coordinate surveyors. Upon request, and if feasible, the area board shall respect the request of a consumer and, when appropriate, family member, for a specific surveyor to conduct the life quality assessment. An area board may provide stipends to surveyors.

(g) A life quality assessment shall be conducted within 90 days prior to a consumer's triennial individual program plan meeting, so that the consumer and regional center may use this information as part of the planning process.

(h) Prior to conducting a life quality assessment, the area board shall meet with the regional center to coordinate the exchange of appropriate information necessary to conduct the assessment and ensure timely followup to identified violations of any legal, civil, or service rights.

(i) Following the conduct of each life quality assessment, the area board shall develop a report of its findings and provide a copy of the report to the consumer, when appropriate, family members, and the

regional center providing case management services to the consumer. In the event that a report identifies alleged violations of any legal, civil, or service right, the area board shall notify the regional center and the department of the alleged violation. The department shall monitor the regional center to ensure that violations are addressed and resolved in a timely manner.

(j) Regional centers shall review information from the life quality assessments on a systemic basis in order to identify training and resource development needs.

(k) Effective August 1, 1999, and annually thereafter, the Organization of Area Boards shall prepare and submit a report to the Governor, the Legislature, and the department describing the activities and accomplishments related to the implementation of this section. The report shall include, but not be limited to, the number of life quality assessments conducted, the number of surveyors, including those provided stipends, a description of the surveyor recruitment process and training program, including any barriers to recruitment, the number, nature, and outcome of any identified violations of legal, civil, or service rights reported to regional centers, and recommendations for improvement in the life quality assessment process.

(l) Implementation of this section shall be subject to an annual appropriation of funds in the state Budget Act for this purpose.

(m) If the department finds, based on the results of the independent study described in subdivision (b), that there is a compelling reason why the area boards should not conduct the life quality assessments, it may select an alternative governmental agency or contract with a nonprofit agency to conduct the life quality assessments as described in this section. The department shall notify the Governor and the Legislature of such a finding, including the reasons for the finding and a description of the alternative method by which the department will ensure the life quality assessment process is completed.

SEC. 34. Section 4629 of the Welfare and Institutions Code is amended to read:

4629. (a) The state shall enter into five-year contracts with regional centers, subject to the annual appropriation of funds by the Legislature.

(b) The contracts shall include a provision requiring each regional center to render services in accordance with applicable provision of state laws and regulations.

(c) (1) The contracts shall include annual performance objectives that shall do both of the following:

(A) Be specific, measurable, and designed to do all of the following:

(i) Assist consumers to achieve life quality outcomes.

(ii) Achieve meaningful progress above the current baselines.

(iii) Develop services and supports identified as necessary to meet identified needs.

(B) Be developed through a public process as described in the department's guidelines that includes, but is not limited to, all of the following:

(i) Providing information, in an understandable form, to the community about regional center services and supports, including budget information and baseline data on services and supports and regional center operations.

(ii) Conducting a public meeting where participants can provide input on performance objectives and using focus groups or surveys to collect information from the community.

(iii) Circulating a draft of the performance objectives to the community for input prior to presentation at a regional center board meeting where additional public input will be taken and considered before adoption of the objectives.

(2) In addition to the performance objectives developed pursuant to this section, the department may specify in the performance contract additional areas of service and support that require development or enhancement by the regional center. In determining those areas, the department shall consider public comments from individuals and organizations within the regional center catchment area, the distribution of services and supports within the regional center catchment area, and review how the availability of services and supports in the regional area catchment area compares with other regional center catchment areas.

(d) Each contract with a regional center shall specify steps to be taken to ensure contract compliance, including, but not limited to, all of the following:

(1) Incentives that encourage regional centers to meet or exceed performance standards.

(2) Levels of probationary status for regional centers that do not meet, or are at risk of not meeting, performance standards. The department shall require that corrective action be taken by any regional center which is placed on probation. Corrective action may include, but is not limited to, mandated consultation with designated representatives of the Association of Regional Center Agencies or a management team designated by the department, or both. The department shall establish the specific timeline for the implementation of corrective action and monitor its implementation. When a regional center is placed on probation, the department shall provide the appropriate area board with a copy of the correction plan, timeline, and any other action taken by the department relating to the probationary status of the regional center.

(e) In order to evaluate the regional center's compliance with its contract performance objectives and legal obligations related to those objectives, the department shall do both of the following:



(1) Annually assess each regional center's achievement of its previous year's objectives and make the assessment, including baseline data and performance objectives of the individual regional centers, available to the public. The department may make a special commendation of the regional centers that have best engaged the community in the development of contract performance objectives and have made the most meaningful progress in meeting or exceeding contract performance objectives.

(2) Monitor the activities of the regional center to ensure compliance with the provisions of its contracts, including, but not limited to, reviewing all of the following:

(A) The regional center's public process for compliance with the procedures set forth in paragraph (2) of subdivision (c).

(B) Each regional center's performance objectives for compliance with the criteria set forth in paragraph (1) of subdivision (c).

(C) Any public comments on regional center performance objectives sent to the department or to the regional centers, and soliciting public input on the public process and final performance standards.

(f) The renewal of each contract shall be contingent upon compliance with the contract including, but not limited to, the performance objectives, as determined through the department's evaluation.

SEC. 35. Section 4631 of the Welfare and Institutions Code is amended to read:

4631. (a) In order to provide to the greatest extent practicable a larger degree of uniformity and consistency in the services, funding, and administrative practices of regional centers throughout the state, the State Department of Developmental Services shall, in consultation with the regional centers, adopt regulations prescribing a uniform accounting system, a uniform budgeting and encumbrancing system, a systematic approach to administrative practices and procedures, and a uniform reporting system which shall include:

(1) Number and costs of diagnostic services provided by each regional center.

(2) Number and costs of services by service category purchased by each regional center.

(3) All other administrative costs of each regional center.

(b) The department's contract with a regional center shall require strict accountability and reporting of all revenues and expenditures, and strict accountability and reporting as to the effectiveness of the regional center in carrying out its program and fiscal responsibilities as established herein.

(c) The Director of Developmental Services shall publish a report of the financial status of all regional centers and their operations by

December 31 of each year. At a minimum, the report shall include each regional center's budget and actual expenditures for the previous fiscal year and each center's budget and projected expenditures for the current fiscal year.

SEC. 36. Section 4635 of the Welfare and Institutions Code is amended to read:

4635. (a) If any regional center finds that it is unable to comply with the requirements of this division or its contract with the state, the regional center shall be responsible for informing the department immediately that it does not expect to fulfill its contractual obligations. Failure to provide the notification to the department in a timely manner shall constitute grounds for possible revocation or nonrenewal of the contract. If any regional center makes a decision to cancel or not renew its contract with the department, the regional center shall give a minimum of 90 days' written notice of its decision.

(b) (1) If the department finds that any regional center is not fulfilling its contractual obligations, the department shall make reasonable efforts to resolve the problem within a reasonable period of time with the cooperation of the regional center, including the action described in paragraph (2) of subdivision (b) of Section 4629 or renegotiation of the contract.

(2) If the department's efforts to resolve the problem are not successful, the department shall issue a letter of noncompliance. The letter of noncompliance shall state the noncompliant activities and establish a specific timeline for the development and implementation of a corrective action plan. The department shall approve the plan and monitor its implementation. Letters of noncompliance shall be made available to the public upon request. The letter of noncompliance shall not include privileged or confidential consumer information or information that would violate the privacy rights of regional center board members or employees. The department shall notify the appropriate area board and shall provide the area board with a copy of the corrective action plan, the timeline, and any other action taken by the department relating to the requirements for corrective action.

(c) If the department finds that any regional center continues to fail in fulfilling its contractual obligations after reasonable efforts have been made, and finds that other regional centers are able to fulfill similar obligations under similar contracts, and finds that it will be in the best interest of the persons being served by the regional center, the department shall take steps to terminate the contract and to negotiate with another governing board to provide regional center services in the area. These findings may also constitute grounds for possible nonrenewal of the contract in addition to, or in lieu of, other grounds.



(d) If the department makes a decision to cancel or not renew its contract with the regional center, the department shall give a minimum of 90 days' written notice of its decision, unless it has determined that the 90 days' notice would jeopardize the health or safety of the regional center's consumers, or constitutes willful misuse of state funds, as determined by the Attorney General. Within 14 days after receipt of the notice, the regional center may make a written protest to the department of the decision to terminate or not renew the contract. In that case, the department shall: (1) arrange to meet with the regional center and the appropriate area board within 30 days after receipt of the protest to discuss the decision and to provide its rationale for the termination or nonrenewal of the contract, and to discuss any feasible alternatives to termination or nonrenewal, including the possibility of offering a limited term contract of less than one fiscal year; and (2) initiate the procedures for resolving disputes contained in Section 4632. To the extent allowable under state and federal law, any outstanding audit exceptions or other deficiency reports, appeals, or protests shall be made available and subject to discussion at the meeting arranged under clause (1).

(e) When terminating or not renewing a regional center contract and negotiating with another governing board for a regional center contract, the department shall do all of the following:

(1) Notify the area board, State Council on Developmental Disabilities, all personnel employed by the regional center, all service providers to the regional center, and all consumers of the regional center informing them that it proposes to terminate or not renew the contract with the regional center, and that the state will continue to fulfill its obligations to ensure a continuity of services, as required by state law, through a contract with a new governing board.

(2) Issue a request for proposals prior to selecting and negotiating with another governing board for a regional center contract. The local area board shall review all proposals and make recommendations to the department.

(3) Request the area board and any other community agencies to assist the state by locating or organizing a new governing board to contract with the department to operate the regional center in the area. Area boards shall cooperate with the department when that assistance is requested.

(4) Provide any assistance which may be required to ensure that the transfer of responsibility to a new regional center will be accomplished with minimum disruption to the clients of the service program.

(f) In no event shall the procedures for termination or nonrenewal of a regional center contract limit or abridge the state's authority to contract with any duly authorized organization for the purpose of service delivery, nor shall these procedures be

interpreted to represent a continued contractual obligation beyond the limits of any fiscal year contract.

SEC. 37. Section 4640.6 of the Welfare and Institutions Code is amended to read:

4640.6. (a) In approving regional center contracts, the department shall ensure that regional center staffing patterns demonstrate that direct service coordination are the highest priority.

(b) Contracts between the department and regional centers shall require that regional centers implement an emergency response system that ensures that a regional center staff person will respond to a consumer, or individual acting on behalf of a consumer, within two hours of the time an emergency call is placed. This emergency response system shall be operational 24 hours per day, 365 days per year.

(c) Contracts between the department and regional centers shall require regional centers to have case management consumer-to-staff ratios that reflect an overall average of 62 consumers to each staff member, and shall require regional centers to have, or contract for, all of the following areas:

(1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.

(2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.

(3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.

(4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.

(5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

(6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinate the regional center quality assurance efforts.

(7) Each regional center shall employ at least one consumer advocate who is a person with developmental disabilities.

(8) Other staffing arrangements related to the delivery of services that the department determines are necessary to ensure maximum cost-effectiveness and to ensure that the service needs of consumers and families are met.

(d) Any regional center proposing a staffing arrangement that substantially deviates from an overall average of 62 consumers to each staff member, shall submit the proposal to the department for

approval prior to implementation. In requesting departmental approval, the regional center shall describe, in detail, its proposed staffing arrangement and the reasons why the staffing arrangement is in the best interest of consumers and families served by the regional center, and shall demonstrate public support for the proposed staffing arrangement.

SEC. 38. Section 4681.3 of the Welfare and Institutions Code is amended to read:

4681.3. (a) Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1997–98 fiscal year, the rate schedule authorized by the department in operation on June 30, 1997, shall be increased based upon the amount appropriated in the Budget Act of 1997 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(c) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on June 30, 1998, shall be increased commencing July 1, 1998, based upon the amount appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(d) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on December 31, 1998, shall be increased January 1, 1999, based upon the cost-of-living adjustments in the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

SEC. 39. Section 4681.4 is added to the Welfare and Institutions Code, to read:

4681.4. (a) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule increased pursuant to subdivision (d) of Section 4681.3 shall be increased by an additional amount on January 1, 1999, based upon the amount appropriated in the Budget Act of 1998 for that purpose. The rate increase permitted by this section shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1999–2000 fiscal year, the rate schedule authorized by the department in operation on December 31, 1999, shall be increased on January 1, 2000, based upon the amount appropriated in the Budget

Act of 1999 for that purpose. The rate increase permitted by this section shall be applied as a percentage and the percentage shall be the same for all providers.

(c) In order to help reduce direct care staff turnover and improve overall quality of care in Alternative Residential Model (ARM) facilities, funds appropriated by the Budget Act of 1998 and the Budget Act of 1999 to increase facility rates effective January 1, 1999, excluding any additional funds appropriated due to increases in benefits under Article 5 (commencing with Section 12200) of Chapter 3 of Part 3 of Division 9, and January 1, 2000, respectively, shall be used only for any of the following:

- (1) Increasing direct care staff salaries, wages, and benefits.
- (2) Providing coverage while direct care staff are in training classes or taking a training or competency test pursuant to Section 4681.5.
- (3) Other purposes approved by the director.

(d) ARM providers shall report to regional centers, in a format and frequency determined by the department, information necessary for the department to determine, through the regional center, compliance with subdivision (c), including, but not limited to, direct care staff salaries, wages, benefits, and staff turnover.

(e) The department shall adopt emergency regulations in order to implement this section, which shall include, but are not limited to, the following:

- (1) A process for enforcing the requirements of subdivisions (c) and (d).
- (2) Consequences to an ARM provider for failing to comply with the requirements of subdivisions (c) and (d), including a process for obtaining approval from the director for the expenditure of funds for other purposes, as permitted by paragraph (3) of subdivision (c).
- (3) A process for adjudicating provider appeals.

SEC. 40. Section 4681.5 is added to the Welfare and Institutions Code, to read:

4681.5. (a) Each direct care staff person employed in an Alternative Residential Model (ARM) facility shall be required to satisfactorily complete two 35-hour competency-based training courses approved, after consultation with the Community Care Facility Direct Care Training Work Group, by the department or pass a department-approved competency test for each of the 35-hour training segments. Each direct care staff person to whom this subdivision applies shall demonstrate satisfactory completion of the competency-based training by passing a competency test applicable to that training segment.

(b) Each direct care staff person employed in an ARM facility prior to January 1, 1999, shall satisfactorily complete the first required competency-based training course or pass a department-approved competency test applicable to that training segment by March 31,

2000, and satisfactorily complete the second competency-based training course or pass a department-approved competency test applicable to that training segment by March 31, 2001.

(c) Each direct care staff person whose employment in an ARM facility commences on or after January 1, 1999, shall satisfactorily complete the first required competency-based training course or pass a department-approved competency test applicable to that training segment within one year from the date the staff person was hired, and satisfactorily complete the second competency-based training course or pass a department-approved competency test applicable to that training segment within two years from the date the person was hired.

(d) A direct care staff person who does not comply with the requirements of this section may not continue to provide direct care to consumers in ARM facilities, unless otherwise approved by the department pursuant to conditions for a waiver specified in regulations adopted pursuant to subdivision (e).

(e) The department shall adopt emergency regulations in order to implement this section. These regulations may include, but are not limited to, all of the following:

(1) Requirements for satisfactory completion of the 70 hours of direct care staff training.

(2) Provisions for enforcement of training requirements.

(3) Continuing education requirements beyond the initial 70 hours of required training.

(4) Provisions for waiving staff training and competency testing requirements, provided that waivers shall not adversely impact the health and safety of ARM facility consumers.

SEC. 41. Section 4690.2 of the Welfare and Institutions Code is amended to read:

4690.2. (a) The Director of Developmental Services shall develop program standards and establish, maintain, and revise, as necessary, an equitable process for setting rates of state payment, based upon those standards, for in-home respite services purchased by regional centers from agencies vendored to provide these services. The Director of Developmental Services may promulgate regulations establishing these standards and the process to be used for setting rates. "In-home respite services" means intermittent or regularly scheduled temporary nonmedical care and supervision provided in the client's own home, for a regional center client who resides with a family member. These services are designed to do all of the following:

(1) Assist family members in maintaining the client at home.

(2) Provide appropriate care and supervision to ensure the client's safety in the absence of family members.

(3) Relieve family members from the constantly demanding responsibility of caring for the client.



(4) Attend to the client's basic self-help needs and other activities of daily living including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by the family members.

(b) The provisions of subdivisions (b) to (f), inclusive, of Section 4691 and subdivisions (a) to (f), inclusive, and subdivision (h) of Section 4691.5 applicable to community-based day programs, shall also apply to in-home respite service vendors for the purpose of establishing standards and an equitable process for setting rates, except:

(1) The process specified in paragraph (4) of subdivision (a) of Section 4691.5 for increasing rates for fiscal year 1990–91 shall apply only to the administrative portion of the rate for eligible in-home respite service vendors, and the amount of funds available for this increase shall not exceed three hundred thousand dollars (\$300,000) of the total amount appropriated for rate increases. The administrative portion of the rate shall consist of the in-home respite service vendor's allowable costs, other than those for respite worker's salary, wage, benefits, and travel. Vendors eligible for this rate increase shall include only those in-home respite service vendors which received a deficiency adjustment in their permanent or provisional rate for fiscal year 1989–90, as specified in paragraph (4) of subdivision (a) of Section 4691.5.

(2) In addition, a rate increase shall also be provided for fiscal year 1990–91, for the salary, wage, and benefit portion of the rate for in-home respite service vendors eligible for the increase. The amount of funds available for this rate increase is limited to the remaining funds appropriated for this paragraph and paragraph (1) for fiscal year 1990–91. The amount of increase which each eligible in-home respite service vendor shall receive shall be limited to the amount necessary to increase the salary, wage, and benefit portion of the rate for respite workers to five dollars and six cents (\$5.06) per hour in salary and wages plus ninety-five cents (\$0.95) in benefits. Vendors eligible for this increase shall include only those in-home respite service vendors whose salary, wage, and benefit portion of their existing provisional or permanent rate, as established by the department for respite workers is below the amounts specified in this paragraph, and the vendor agrees to reimburse its respite workers at no less than these amounts during fiscal year 1990–91 and thereafter. In order to establish rates pursuant to this paragraph, existing programs receiving a permanent or provisional rate shall submit to the department, the program, cost, and other information specified by the department for either the 1988 calendar year, or for the 1988–89 fiscal year. The specified information shall be submitted on forms developed by the department, not later than 45 days following receipt of the required forms from the department, after the effective date of this section. Programs which fail to submit the

required information within the time specified shall have payment of their permanent or provisional rate suspended until the required information has been submitted.

(3) Effective July 1, 1990, and pursuant to the rate methodology developed by the department, the administrative portion and the salary, wage, and benefit portion of the rates for in-home respite service vendors currently receiving a provisional or permanent rate shall be combined and paid as a single rate.

(4) Rate increases for fiscal year 1990–91 shall be limited to those specified in paragraphs (1) and (2). For fiscal year 1991–92 and all succeeding fiscal years, the provisions of subdivision (c) of Section 4691, which specify that any rate increases shall be subject to the appropriation of sufficient funds in the Budget Act, shall also apply to rates for in-home respite service vendors.

(5) For the 1998–99 fiscal year, an in-home respite service vendor shall receive rate increases pursuant to subdivision (e) of Section 4691.5. Any rate increase shall be subject to the appropriation of funds pursuant to the Budget Act.

(6) The rate methodology developed by the department may include a supplemental amount of reimbursement for travel costs of respite workers using their private vehicles to and from and between respite sites. The supplemental amount shall be the minimum rate for travel reimbursement for state employees.

SEC. 42. Section 4690.3 is added to the Welfare and Institutions Code, to read:

4690.3. (a) For the 1998–99 fiscal year, rates for in-home respite services agencies that are vendored pursuant to Section 4690.2 and the department's regulations to provide in-home respite services shall be increased based on the amount appropriated in the Budget Act of 1998 for the purpose of increasing the salary, wage, and benefit portion of the rate for in-home respite services workers. Agencies shall reimburse their respite workers at no less than the increased amount in their rate for the 1998–99 fiscal year and thereafter.

(b) For the 1998–99 fiscal years an individual who provides in-home respite services, pursuant to vendorization pursuant to the department's regulations, shall also receive a rate increase pursuant to subdivision (a).

SEC. 43. Section 4690.4 is added to the Welfare and Institutions Code, to read:

4690.4. (a) Sections 4690.2, 4691, and 4691.5, which relate to in-home respite service agencies and community-based day programs, shall apply in the 1998–99 fiscal year with the following exceptions:

(1) The 1997–98 fiscal year allowable costs and consumer attendance data submitted to the department by September 30, 1998, shall not be utilized by the department to determine a new mean rate

and allowable range of rates, pursuant to regulations, but may be used only in developing a new rate system.

(2) The allowable range of rates and mean rate established for the 1997–98 fiscal year shall be continued.

(3) The rate for new programs shall be the mean rate determined for the same type of program and staff-to-consumer ratio for the 1997–98 fiscal year.

(b) The department shall, in consultation with stakeholder organizations, develop performance based consumer outcome rate systems for community-based day programs and in-home respite services. If rates for community-based day programs are increased in the 1998–99 fiscal year pursuant to paragraphs (1) to (3), inclusive, of subdivision (e) of Section 4691.5, and rates for in-home respite services are increased in the 1998–99 fiscal year pursuant to paragraph (5) of subdivision (b) of Section 4690.2, as added by the act adding this section to the Welfare and Institutions Code, then effective September 1, 1998, and until such time as the new rate systems are implemented, or unless funds are otherwise appropriated for rate adjustments, rates shall be frozen.

SEC. 44. Section 4691.5 of the Welfare and Institutions Code is amended to read:

4691.5. The ratesetting methodology, to be established pursuant to subparagraph (C) of paragraph (3) of subdivision (b) of Section 4691 shall include, but need not be limited to, all of the following:

(a) A process for establishing rates during fiscal year 1990–91 for new programs and existing programs receiving a provisional or permanent rate.

(1) The rate for new programs shall be the mean rate determined for the same type of day program and staff-to-client ratio. This rate shall be a temporary rate. Determination of the mean rate for new programs shall be based on the program, cost, and other information of existing programs receiving a permanent rate, using allowable costs and client attendance information of those existing programs. In order to establish rates pursuant to this paragraph existing programs receiving a permanent rate shall submit to the department, the program, cost, and other information specified by the department for either calendar year 1988 or fiscal year 1988–89. The specified information shall be submitted on forms developed by the department, not later than 45 days following receipt of the required forms from the department, after the effective date of this section. Programs which fail to submit the required information within the time specified shall have payment of their permanent rate suspended until the required information has been submitted.

(2) Except as provided in paragraph (4) the rate for existing programs receiving a provisional rate, whose rate would otherwise expire during fiscal year 1990–91, shall be extended at the provisional rate until September 1, 1991.



(3) Except as provided in paragraph (4) below, the rate for existing programs receiving a permanent rate shall be reestablished at the permanent rate until June 30, 1991.

(4) The rate for existing programs receiving a provisional or permanent rate as specified in paragraph (2) and paragraph (3) shall be increased for all programs eligible for the increase. Eligible programs shall include only those programs which received a deficiency adjustment in their permanent or provisional rate for fiscal year 1989–90, based on calendar year 1988 program and cost information submitted to the department, pursuant to the stipulated order in the case of California Association of Rehabilitation Facilities et al. v. State of California, Sacramento County Superior Court Case No. 355326, and the adjustment was insufficient to fund the entire deficiency. The amount of funds available for the increase is limited to the one million dollars (\$1,000,000) appropriated for that purpose for fiscal year 1990–91, and it shall be distributed proportionately among all eligible programs. The amount of increase which each eligible program shall receive toward its remaining deficiency, based on calendar year 1988 program and cost information, shall be equal to the percentage that one million dollars (\$1,000,000) represents of the total deficiency, based on calendar year 1988 program and cost information, for all eligible programs.

(b) A process for establishing rates during fiscal year 1991–92 for new programs and existing programs receiving a temporary, provisional, or permanent rate.

(1) The rate for existing programs receiving a permanent rate, shall be determined based on fiscal year 1989–90 program, cost, and other information submitted to the department and regional center. The ratesetting process shall include, but shall not be limited to, all of the following:

(A) A process for determination of a mean rate and an allowable range of rates for the same type of day program and staff-to-client ratio. The mean rate shall be determined using those programs' allowable costs and client attendance and the allowable range of rates shall be defined as the rates of those programs included between the 10th and 90th percentiles.

(B) The rates for existing programs receiving a permanent rate shall be increased or decreased to their allowable costs for fiscal year 1991–92, as follows:

(i) The rate shall be decreased if the program's allowable costs and client attendance, for fiscal year 1989–90, determined pursuant to the regulations, would result in a rate that is lower than its existing permanent rate.

(ii) The rate shall be increased if the program's allowable costs and client attendance for fiscal year 1989–90, determined pursuant to the regulations, would result in a rate that is higher than its existing

permanent rate and its existing permanent rate is below or within the allowable range of rates.

(iii) No rate increase shall be provided that would result in the rate exceeding the allowable range of rates. No increase shall be provided for programs whose existing permanent rate is above the allowable range of rates. The amount of funds appropriated for that purpose for fiscal year 1991–92 shall be distributed only to those programs eligible for the increase.

(C) A process for the reduction or increase in the rate of any program whose existing permanent rate is not within the allowable range of rates. This process shall be based upon all of the following:

(i) For programs whose existing permanent rates are above the allowable range of rates, their existing permanent rate shall be reduced by 5 percent or to the allowable range, whichever is less.

(ii) For programs whose existing permanent rates are below the allowable range of rates, after the increase specified in clause (ii) of subparagraph (B) their rate shall be increased, up to the allowable range, in proportion to the amount of funds obtained from reducing the rate of programs whose rates are above the range.

(2) The rate for new programs shall be the mean rate determined pursuant to the process in paragraph (1) for the same type of day program and staff-to-client ratio using the program, cost, and other information submitted by providers receiving a permanent rate.

(3) The rate for existing programs receiving a provisional rate, whose rate expired during fiscal year 1990–91 and was extended until September 1, 1991, shall be determined pursuant to the process specified in paragraph (1) for permanent rates, except that the determination shall be based upon 12 consecutive months of representative costs incurred by the program during the period it was receiving its provisional rate. The program shall submit these costs and other program information, designated by the department, to the department within the time frames specified in the regulations. If the program has not incurred or cannot provide 12 consecutive months of representative costs, the department may determine the rate based on less than 12 consecutive months of representative costs.

(4) The rate for existing programs receiving a provisional rate, whose rate will expire in July or August of 1991, shall be extended until September 1, 1991, and then determined pursuant to the process specified in paragraph (3).

(c) A process for establishing rates during fiscal year 1992–93 for new programs and existing programs receiving a temporary or permanent rate:

(1) The rate for new programs shall be the mean rate, determined pursuant to the process in paragraph (2) of subdivision (b) for fiscal year 1991–92, for the same type of day program and staff-to-client ratio.

(2) The rate for existing programs receiving a temporary rate shall be continued at the rate established for fiscal year 1991–92, until the rate expires or a permanent rate is established pursuant to the process in paragraph (4) of subdivision (b) for fiscal year 1991–92.

(3) The rate for existing programs receiving a permanent rate shall be reestablished at the rate established for fiscal year 1991–92, except for programs whose rates are not within the allowable range of rates. For those programs whose rates are not within the allowable range, their rates shall be reduced or increased pursuant to the process in subparagraph (C) of paragraph (1) of subdivision (b) for fiscal year 1991–92.

(d) A process for establishing rates during fiscal year 1993–94 for new programs and existing programs receiving a temporary or permanent rate:

(1) The rate for existing programs receiving a permanent rate shall be determined based on fiscal year 1991–92 program, cost, and other information submitted to the department and regional center. The ratesetting process shall include the process specified in paragraph (1) of subdivision (b) for fiscal year 1991–92, except that the allowable range of rates shall be determined by computing 50 percent of the mean rate for fiscal year 1993–94 and converting that amount into a range of rates, distributed equally above and below the mean. This process shall compare the range of rates computed for fiscal year 1993–94 with the range of rates calculated for fiscal year 1991–92 based on 80 percent of the programs, and shall use the lesser of the two ranges in the comparison as the allowable range of rates. Once established, this range shall be permanent.

(2) The rate for new programs shall be the mean rate determined pursuant to the process in paragraph (1) for the same type of day program and staff-to-client ratio using the program, cost, and other information submitted by providers receiving a permanent rate.

(3) The rate for existing programs receiving a temporary rate shall be continued at the established rate until the program has incurred 12 consecutive months of representative costs within the timeframes specified in the regulations. Once the representative costs have been incurred, the rate shall be determined pursuant to the process specified in paragraph (1) for permanent rates.

(e) A process for establishing rates, during fiscal year 1994–95 and each alternative fiscal year thereafter, for new programs and existing programs receiving a temporary or permanent rate. The process shall be the same as that specified in subdivision (c) for determining, continuing, and reestablishing rates, but shall be based on the program, cost, and other information submitted to the department and regional center for establishment of rates for fiscal year 1993–94 and each alternative fiscal year thereafter, except for the following:

(1) For the 1998–99 fiscal year, the rates for existing community-based day programs receiving a permanent rate shall be

increased if the program's allowable costs and client attendance, for the 1995-96 fiscal year, determined pursuant to the regulations, would result in a rate that is higher than its existing permanent rate and its existing permanent rate is below or within the allowable range of rates. The rate shall not be decreased if the program's allowable costs and client attendance for the 1995-96 fiscal year, determined pursuant to the regulations, would result in a rate that is lower than its existing permanent rate.

(2) For the 1998-99 fiscal year, existing community-based day programs receiving a permanent rate, and whose permanent rate is still below the lower limit of the allowable range of rates for like programs after receiving an increase pursuant to paragraph (1), shall receive an increase in their permanent rate up to the lower limit of the allowable range of rates.

(3) The requirements of subdivision (c) of Section 4691, which specify that any rate increases shall be subject to the appropriation of sufficient funds in the Budget Act, shall also apply to rates governed by paragraphs (1) and (2).

(f) A process for establishing rates, during fiscal year 1995-96 and each alternative fiscal year thereafter, for new programs and existing programs receiving a temporary or permanent rate. The process shall be the same as that specified in subdivision (d) except for the following:

(1) The rate for programs receiving a permanent rate shall be based on program, cost, and other information submitted to the department and regional center for fiscal year 1993-94 and each alternative fiscal year thereafter.

(2) The allowable range of rates, permanently established during fiscal year 1993-94, shall be applied to the mean rate determined for fiscal year 1995-96 and each alternative fiscal year thereafter.

(3) Existing programs receiving a permanent rate whose rates are not within the allowable range of rates shall, by September 1, 1995, have their rates reduced or increased as follows:

(A) For programs whose existing permanent rates are above the allowable range of rates, their rate shall be reduced to the allowable range.

(B) For programs whose existing rates are below the allowable range of rates, their rate shall be increased up to the allowable range in proportion to the amount of funds obtained from reducing the rate of programs whose rates are above the range.

(g) A process for establishing a uniform supplemental rate of reimbursement for programs serving nonambulatory clients, as determined by the department.

(h) A process for notifying the program of the established rate.

SEC. 45. Section 4701 of the Welfare and Institutions Code is amended to read:

4701. “Adequate notice” means a written notice informing the applicant, recipient, and authorized representative of at least all of the following:

(a) The action that the service agency proposes to take, including a statement of the basic facts upon which the service agency is relying.

(b) The reason or reasons for that action.

(c) The effective date of that action.

(d) The specific law, regulation, or policy supporting the action.

(e) The responsible state agency with whom a state appeal may be filed, including the address of the state agency director.

(f) Information on availability of advocacy assistance, including referral to the state hospital or regional center clients’ rights advocate, area board, publicly funded legal services corporations, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under federal Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act.

(g) The fair hearing procedure, including deadlines, access to service agency records under Article 5 (commencing with Section 4725), and the availability of mediation which shall be voluntary for both the claimant and the service agency.

(h) An explanation that a request for mediation may constitute a waiver of the rights of a medicaid home and community-based waiver participant to receive a fair hearing decision within 90 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier, as specified in subdivision (c) of Section 4711.5.

(i) That if a request for a fair hearing by a recipient is postmarked or received by a service agency no later than 10 days after receipt of the notice of the proposed action mailed pursuant to subdivision (a) of Section 4710, current services shall continue as provided in Section 4715. The notice shall be in clear, nontechnical language in English. If the claimant or authorized representative does not comprehend English, the notice shall be provided in such other language as the claimant or authorized representative comprehends.

(j) A statement indicating whether the recipient is a participant in the home and community-based services waiver.

SEC. 46. Section 4702.6 of the Welfare and Institutions Code is amended to read:

4702.6. “Hearing request form” means a document that shall include the name, address, and birth date of the claimant, date of request, reason for the request, and name, address, and relationship to the claimant of the authorized representative, if any, and whether the claimant is a participant in the medicaid home and community-based waiver. The hearing request form shall also indicate whether the claimant or his or her authorized

representative is requesting mediation. A copy of the appointment of the authorized representative, by the claimant or the area board if any, shall also be included.

SEC. 47. Section 4704 of the Welfare and Institutions Code is amended to read:

4704. "Service agency" means any developmental center or regional center that receives state funds to provide services to persons with developmental disabilities.

SEC. 48. Section 4704.5 of the Welfare and Institutions Code is amended to read:

4704.5. For purposes of Sections 4710.9, 4711, 4711.5, 4711.7, 4712, and 4712.5, the director of the responsible state agency includes a designee thereof, which may, but need not, be a public or private agency that contracts with the State Department of Developmental Services for the provision of hearing officers or mediators.

SEC. 49. Section 4705 of the Welfare and Institutions Code is amended to read:

4705. (a) Every service agency shall, as a condition of continued receipt of state funds, have an agency fair hearing procedure for resolving conflicts between the service agency and recipients of, or applicants for, service. The State Department of Developmental Services shall promulgate regulations to implement this chapter by July 1, 1999, which shall be binding on every service agency.

Any public or private agency receiving state funds for the purpose of serving persons with developmental disabilities not otherwise subject to the provisions of this chapter shall, as a condition of continued receipt of state funds, adopt and periodically review a written internal grievance procedure.

(b) An agency that employs a fair hearing procedure mandated by any other statute shall be considered to have an approved procedure for purposes of this chapter.

(c) The service agency's mediation and fair hearing procedure shall be stated in writing, in English and any other language that may be appropriate to the needs of the consumers of the agency's service. A copy of the procedure and a copy of the provisions of this chapter shall be prominently displayed on the premises of the service agency.

(d) All recipients and applicants, and persons having legal responsibility for recipients or applicants, shall be informed verbally of, and shall be notified in writing in a language which they comprehend of, the service agency's mediation and fair hearing procedure when they apply for service, when they are denied service, and when notice of service modification is given pursuant to Section 4710.

(e) If, in the opinion of any person, the rights or interests of a claimant who has not personally authorized a representative will not be properly protected or advocated, the local area board and the clients' right advocate assigned to the regional center shall be

notified, and the area board may appoint a person or agency as representative, pursuant to Section 4590, to assist the claimant in the mediation and fair hearing procedure. The appointment shall be in writing to the authorized representative and a copy of the appointment shall be immediately mailed to the service agency director.

SEC. 50. Section 4706 is added to the Welfare and Institutions Code, to read:

4706. (a) Except as provided in subdivision (b) to the extent permitted by federal law, all issues concerning the rights of persons with developmental disabilities to receive services under this division shall be decided under this chapter, including those issues related to fair hearings, provided under the medicaid home- and community-services waiver granted to the State Department of Health Services.

(b) Whenever a fair hearing under this chapter involves services provided under the medicaid home- and community-based services waiver, the State Department of Health Services shall retain the right, as provided in Section 4712.5, to review and modify any decision reached under this chapter.

SEC. 51. Section 4707 is added to the Welfare and Institutions Code, to read:

4707. By July 1, 1999, the State Department of Developmental Services shall implement a mediation process for resolving conflicts between regional centers and recipients of services specified in this chapter. Regulations implementing the mediation process shall be adopted by July 1, 2000.

SEC. 52. Section 4710.5 of the Welfare and Institutions Code is amended to read:

4710.5. (a) Any applicant for or recipient of services, or authorized representative of the applicant or recipient, who is dissatisfied with any decision or action of the service agency which he or she believes to be illegal, discriminatory, or not in the recipient's or applicant's best interests, shall, upon filing a request within 30 days after notification of the decision or action complained of, be afforded an opportunity for a fair hearing. An opportunity for mediation shall also be offered at this time.

(b) The request for a fair hearing and for mediation shall be stated in writing on a hearing request form provided by the service agency.

(c) If any person makes a request for mediation or a fair hearing other than on the hearing forms, the employee of the service agency who hears or receives the request shall provide the person with a hearing request form and shall assist the person in filling out the form if the person requires or requests assistance. Any employee who willfully fails to comply with this requirement shall be guilty of a misdemeanor.



(d) The hearing request form shall be directed to the director of the service agency responsible for the action complained of under subdivision (a). The service agency director shall simultaneously send a copy of the hearing request form to the department and the director of the responsible state agency or his or her designee pursuant to Section 4704.5 within five days of the service agency director's receipt of the request. The department shall keep a file of all hearing request forms.

SEC. 53. Section 4710.6 of the Welfare and Institutions Code is amended to read:

4710.6. (a) Upon receipt by the service agency director of the hearing request form, the service agency director shall immediately notify in writing the claimant, the claimant's guardian or conservator, parent of a minor, and authorized representative of the claimant's fair hearing rights in connection with the fair hearing, and, if mediation or an informal meeting has been requested, with those procedures, including:

(1) The opportunity to be present in all proceedings and to present written and oral evidence.

(2) The opportunity to confront and cross-examine witnesses.

(3) The right to appear in person with counsel or other representatives of his or her own choosing.

(4) The right to access to records pursuant to Article 5 (commencing with Section 4725).

(5) The right to an interpreter.

(b) The written notification of rights pursuant to subdivision (a) shall also include the following:

(1) Information on availability of advocacy assistance, including referral to the state hospital or regional center clients' rights advocate, area board, publicly funded legal services corporations, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under federal Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act.

(2) The proposed date, time and place for a voluntary informal meeting, if desired by the claimant or his or her authorized representative, with the service agency director or the director's designee.

(3) Information that if a voluntary informal meeting is requested by the claimant, it shall be held within 10 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier.

(4) The option of requesting mediation prior to a fair hearing, as provided in Section 4711.5. Nothing in this section shall preclude the claimant or his or her authorized representative from proceeding directly to a fair hearing in the event that mediation is unsuccessful.



(c) The fair hearing shall be completed and a final administrative decision rendered within 90 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier, unless the fair hearing request has been withdrawn or the time period has been extended in accordance with this chapter.

(d) Prior to a voluntary informal meeting, voluntary mediation or a fair hearing, the claimant or his or her authorized representative shall have the right to examine any or all documents contained in the individual's service agency file. Access to records shall be provided pursuant to Article 5 (commencing with Section 4725).

SEC. 54. Section 4710.7 of the Welfare and Institutions Code is amended to read:

4710.7. (a) Immediately upon receipt of the hearing request form, the service agency director, or his or her designee shall offer in writing to meet informally with the claimant and his or her authorized representative to resolve the issue or issues that are the subject of the fair hearing. The written notice shall state that the claimant or his or her authorized representative may decline an informal meeting.

(b) If an informal meeting is held, it shall be conducted by the service agency director or his or her designee. The service agency director or his or her designee shall notify the applicant or recipient and his or her authorized representative of the decision of the informal meeting in writing within five days of the meeting.

(c) The written decision of the service agency director or his or her designee shall:

- (1) Identify the issues presented by the appeal.
- (2) Rule on each issue identified.
- (3) State the facts supporting each ruling.
- (4) Identify the laws, regulations, and policies upon which each ruling is based.
- (5) Explain the procedure for appealing the service agency director's decision to the responsible state agency director.

(d) Prior to the meeting, the claimant or his or her authorized representative shall have the right to examine any documents contained in the individual's service agency file. Access to records shall be provided pursuant to Article 5 (commencing with Section 4725).

SEC. 55. Section 4710.8 of the Welfare and Institutions Code is amended to read:

4710.8. (a) At an informal meeting, the claimant shall have the rights stated pursuant to subdivision (a) of Section 4710.6.

(b) An informal meeting shall be held at a time and place reasonably convenient to the claimant and the authorized representative.

(c) An informal meeting shall be conducted in the English language. However, if the claimant, the claimant's guardian or

conservator, the parent of a minor claimant, or the authorized representative does not understand English, an interpreter shall be provided who is competent and acceptable to both the person requiring the interpreter and the service agency director or the director's designee. Any cost of an interpreter shall be borne by the service agency.

SEC. 56. Section 4710.9 of the Welfare and Institutions Code is repealed.

SEC. 57. Section 4710.9 is added to the Welfare and Institutions Code, to read:

4710.9. (a) If the claimant or his or her authorized representative is satisfied with the decision of the service agency following an informal meeting, he or she shall withdraw the request for a hearing on the matter decided. The decision of the service agency shall go into effect 10 days after the receipt of the withdrawal of the request for a fair hearing by the service agency. The service agency shall immediately forward a copy of the withdrawal to the department and to the director of the responsible state agency or his or her designee pursuant to Section 4704.5.

(b) If the claimant or his or her authorized representative has declined an informal meeting or is dissatisfied with the decision of the service agency and does not request mediation, the matter shall proceed to a fair hearing. The service agency shall immediately notify the director of the responsible state agency that the fair hearing request has not been withdrawn. A recommendation for consolidation pursuant to Section 4712.2 to the director of the responsible state agency may be made at this time.

SEC. 58. Section 4711 of the Welfare and Institutions Code is amended to read:

4711. Upon receipt of the hearing request form, where a fair hearing has been requested but mediation has not, the responsible state agency director shall immediately notify the claimant, the claimant's legal guardian or conservator, the parent of a minor claimant, the claimant's authorized representative, and the service agency director in writing of all the following information applicable to fair hearings. Where the hearing request form contains a request for a fair hearing and mediation, the notifications shall be made separately, and each notice shall contain only the information applicable to the particular type of proceeding.

(a) The time, place, and date of the fair hearing or mediation, as applicable, if agreed to by the service agency.

(b) The rights of the parties at the fair hearing pursuant to Section 4710.6 or mediation, as applicable, pursuant to Section 4711.5.

(c) The availability of advocacy assistance pursuant to paragraph (1) of subdivision (b) of Section 4710.6 for both mediation and fair hearings.



(d) The name, address, and telephone number of the persons or offices designated by the director of the responsible state agency, as applicable, to conduct fair hearings, mediate disputes, and to receive requests for continuance or consolidation.

SEC. 59. Section 4711.5 is added to the Welfare and Institutions Code, to read:

4711.5. (a) Upon receipt of the written request for mediation, the service agency shall be given five days to accept or decline mediation.

(b) If the service agency declines mediation, the notice of that decision shall be sent immediately to the claimant, his or her authorized representative, and the director of the responsible state agency.

(c) (1) If the service agency accepts mediation, the service agency shall immediately send notice of that decision to the claimant, his or her authorized representative, and the director of the responsible state agency.

(2) Within five days after the receipt of the notice of the service agency's decision regarding mediation, the responsible state agency or the designee of the responsible state agency shall notify the claimant, his or her authorized representative, and the service agency of the information applicable to voluntary mediation specified in Section 4711. The mediation shall be held within 20 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier, unless a continuance is granted to the claimant at the discretion of the mediator.

(3) A continuance granted pursuant to paragraph (2) shall constitute a waiver of medicaid home and community-based services of the participant's right to a decision within 90 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier. The extension of time for the final decision resulting from the continuance shall only be as long as the time period of the continuance.

(d) Mediation shall be conducted in an informal, nonadversarial manner, and shall incorporate the rights of the claimant contained in Section 4710.6.

(e) The State Department of Developmental Services shall contract with the mediators that meet the following requirements:

(1) Familiarity with the provisions of this division and implementing regulations, familiarity with the process of reconciling differences in a nonadversarial, informal manner.

(2) The person is not in the business of providing or supervising services provided to regional centers or to regional center consumers.

(f) During the course of the mediation, the mediator may meet separately with the participants to the mediation, and may speak

with any party or parties confidentially in an attempt to assist the parties to reach a resolution that is acceptable to all parties.

(g) The mediator shall voluntarily disqualify himself or herself and withdraw from any case in which he or she cannot be fair and impartial. Any party may request the disqualification of the mediator by filing an affidavit, prior to the voluntary mediation, stating with particularity the grounds upon which it is claimed that a fair and impartial mediation cannot be accorded. The issue shall be decided by the mediator.

(h) Either the service agency or the claimant or his or her authorized representative may withdraw at any time from the mediation and proceed to a fair hearing.

SEC. 60. Section 4711.7 is added to the Welfare and Institutions Code, to read:

4711.7. (a) If the issue or issues involved in the mediation are resolved to the satisfaction of both parties, the mediator shall prepare a written resolution. Agreement of the claimant or his or her authorized representative to the final solution shall be accompanied by a withdrawal, in writing, of the fair hearing request. The final resolution shall go into effect 10 days after receipt of the withdrawal of the request for a fair hearing by the service agency. The mediator shall immediately forward a copy of the withdrawal to the director of the responsible state agency.

(b) If the mediation fails to resolve an issue or issues to the satisfaction of the claimant, or his or her authorized representative, the matter shall proceed to fair hearing with respect to the unresolved issue or issues as provided under this chapter, and the mediator shall immediately notify the director of the responsible state agency of the outcome of the mediation.

SEC. 61. Section 4712 of the Welfare and Institutions Code is amended to read:

4712. (a) The fair hearing shall be held within 50 days of the date the hearing request form is postmarked or received by the service agency, whichever is earlier, unless a continuance based upon a showing of good cause has been granted to the claimant. The service agency may also request a continuance based upon a showing of good cause, provided that the granting of the continuance does not extend the time period for rendering a final administrative decision beyond the 90-day period provided for in this chapter. For purposes of this section, good cause includes, but is not limited to, the following circumstances:

(1) Death of a spouse, parent, child, brother, sister, grandparent of the claimant or authorized representative, or legal guardian or conservator of the claimant.

(2) Personal illness or injury of the claimant or authorized representative.

(3) Sudden and unexpected emergencies, including, but not limited to, court appearances of the claimant or authorized representative, conflicting schedules of the authorized representative if the conflict is beyond the control of the authorized representative.

(4) Unavailability of a witness or evidence, the absence of which would result in serious prejudice to the claimant.

(5) An intervening request by the claimant or his or her authorized representative for mediation.

(b) Notwithstanding Sections 19130, 19131, and 19132 of the Government Code, the department shall contract for the provision of independent hearing officers. Hearing officers shall have had at least two years of full-time legal training at a California or American Bar Association accredited law school or the equivalent in training and experience as established by regulations to be promulgated by the department pursuant to Section 4705. These hearing officers shall receive training in the law and regulations governing services to developmentally disabled individuals and administrative hearings. The State Department of Developmental Services shall seek the advice of the State Council on Developmental Disabilities in the development of training materials and the implementation of training procedures by the department.

(c) The hearing officer shall not be an employee, agent, board member, or contractor of the service agency against whose action the appeal has been filed, or a spouse, parent, child, brother, sister, grandparent, legal guardian, or conservator of the claimant, or any person who has a direct financial interest in the outcome of the fair hearing, or any other interest which would preclude a fair and impartial hearing.

(d) When requested by the hearing officer, a service agency shall provide information relevant to the matter under appeal to the hearing officer prior to the fair hearing. Immediate notice of the documents provided to the hearing officer shall be mailed by the service agency to the claimant and the authorized representative, either of whom may submit additional documentation to the hearing officer prior to the hearing.

(e) The fair hearing shall be held at a time and place reasonably convenient to the claimant and the authorized representative.

(f) Merits of a pending fair hearing shall not be discussed between the hearing officer and a party outside the presence of the other party.

(g) The hearing officer shall voluntarily disqualify himself or herself and withdraw from any case in which he or she cannot accord a fair and impartial hearing or consideration. Any party may request the disqualification of the hearing officer by filing an affidavit, prior to the taking of evidence at a hearing, stating with particularity the

grounds upon which it is claimed that a fair and impartial hearing cannot be accorded. The issue shall be decided by the hearing officer.

(h) Both parties to the fair hearing shall have the rights specified in subdivision (a) of Section 4710.6.

(i) The fair hearing need not be conducted according to the technical rules of evidence and those related to witnesses. Any relevant evidence shall be admitted. All testimony shall be under oath or affirmation which the hearing officer is empowered to administer.

(j) A recording shall be made of the proceedings before the hearing officer. Any cost of recording shall be borne by the responsible state agency.

(k) The fair hearing shall be conducted in the English language. However, if the claimant, the claimant's guardian or conservator, parent of a minor claimant, or authorized representative does not understand English, an interpreter shall be provided by the responsible state agency.

(l) The fair hearing shall be open to the public except at the request of the claimant or authorized representative or when personnel matters are being reviewed.

SEC. 62. Section 4712.5 of the Welfare and Institutions Code is amended to read:

4712.5. (a) Except as provided in subdivision (c), within 10 days of the concluding day of the state hearing, but not later than 80 days following the date the hearing request form was postmarked or received, whichever is earlier, the hearing officer shall render a written decision and shall transmit the decision to each party and to the director of the responsible state agency, along with notification that this is the final administrative decision, that each party shall be bound thereby, and that either party may appeal the decision to a court of competent jurisdiction within 90 days of the receiving notice of the final decision.

(b) The hearing officer's decision shall be in ordinary and concise language and shall contain a summary of the facts, a statement of the evidence from the proceedings that was relied upon, a decision on each of the issues presented, and an identification of the statutes, regulations, and policies supporting the decision.

(c) Where the decision involves an issue arising from the federal home- and community-based service waiver program, the hearing officer's decision shall be a proposed decision submitted to the Director of Health Services as the single state agency for the medicaid program. Within 90 days following the date the hearing request form is postmarked or received, whichever is earlier, the director may adopt the decision as written or decide the matter on the record. If the Director of Health Services does not act on the proposed decision within 90 days, the decision shall be deemed to be adopted by the Director of Health Services. The final decision shall



be immediately transmitted to each party, along with the notice described in subdivision (a). If the decision of the Director of Health Services differs from the proposed decision of the hearing officer, a copy of that proposed decision shall also be served upon each party.

SEC. 63. Section 4712.7 is added to the Welfare and Institutions Code, to read:

4712.7. In addition to any other delegation of authority granted to the Director of Health Services, the director may delegate his or her authority to adopt final decisions under this chapter to hearing officers described in subdivision (b) of Section 4712 to the extent deemed appropriate by the director. The delegation shall be in writing.

SEC. 64. Section 4715 of the Welfare and Institutions Code is amended to read:

4715. (a) Except as otherwise provided in this section, if a request for a hearing is postmarked or received by the service agency no later than 10 days after receipt of the notice of the proposed action mailed pursuant to subdivision (a) of Section 4710, services that are being provided pursuant to a recipient's individual program plan shall be continued during the appeal procedure up to and including the 10th day after receipt of any of the following:

(1) Receipt by the service agency, following an informal meeting, of the withdrawal of the fair hearing request pursuant to Section 4710.9.

(2) Receipt by the service agency, following mediation, of the withdrawal of the fair hearing request pursuant to subdivision (a) of Section 4711.4.

(3) Receipt by the recipient of the final decision of the hearing officer or single stage agency pursuant to subdivisions (a) and (c) of Section 4712.5.

(b) Services continued pursuant to subdivision (a) may be modified by agreement of the parties in accordance with the decision of the interdisciplinary team and the individual program plan.

(c) Any appeal to a court by either party shall not operate as a stay of enforcement of the final administrative decision, provided that either party may seek a stay of enforcement from any court of competent jurisdiction.

SEC. 65. Section 5328.35 is added to the Welfare and Institutions Code, to read:

5328.35. The State Department of Mental Health shall develop policies and procedures no later than 30 days after the effective date of the Budget Act of 1998, at each state hospital, to notify Members of the Legislature who represent the district in which the state hospital is located, local law enforcement, and designated local government officials in the event of a patient escape or walkaway.

SEC. 66. Section 5586 is added to the Welfare and Institutions Code, to read:

5586. During the 1998–99 fiscal year, the Metropolitan State Hospital shall, at a minimum, collect data on the use of medications, and the use of restraint and seclusion, including the number and duration of restraint and seclusion incidents, in the youth program. This information shall be provided to the State Department of Mental Health Deputy Director of Long-Term Care Services and the appropriate policy committees and the fiscal committees of the Legislature on a quarterly basis.

SEC. 67. Section 5587 is added to the Welfare and Institutions Code, to read:

5587. The Metropolitan State Hospital Youth Program’s admission policy shall require the referring agency to document all placement attempts prior to admission. The youth program’s discharge planning policy shall require the referring agency to document all attempts to place the child during the discharge planning process.

SEC. 68. Section 11265.9 is added to the Welfare and Institutions Code, to read:

11265.9. Whenever aid to an individual or family is discontinued under this chapter for any reason other than fraud, the department shall include, in the notice of termination of aid, a brief summary of the requirements for transitional Medi-Cal benefits provided for pursuant to Sections 14005.8, 14005.81, and 14005.85, and Section 50243 of Title 22 of the California Code of Regulations, as well as a form that the individual or family may fill out and return to request transitional Medi-Cal benefits.

SEC. 69. Section 14005.30 of the Welfare and Institutions Code is repealed.

SEC. 70. Section 14005.30 is added to the Welfare and Institutions Code, to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to expand eligibility for Medi-Cal under subdivision (a) by establishing the amount of countable resources individuals or families

are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family of one shall be allowed to retain countable resources in the amount of three thousand dollars (\$3,000).

(c) Subdivision (b) shall be applied retroactively to January 1, 1998.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

SEC. 71. Section 14005.8 of the Welfare and Institutions Code is amended to read:

14005.8. (a) (1) To the extent required by Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code and regulations adopted pursuant thereto, a family who was receiving aid pursuant to a state plan approved under Part A of Subchapter IV (commencing with Section 601) of Title 42 of the United States Code in at least three of the six months immediately preceding the month in which that family became ineligible for that assistance due to increased hours of employment, income from employment, or the loss of earned income disregards, shall remain eligible for health care services as provided in this chapter during the immediately succeeding six-month period.

(2) The department shall terminate extensions of health care services authorized by paragraph (1) as required under federal law.

(b) The department shall notify persons eligible under subdivision (a) of their right to continued health care services for each six-month period and a description of their reporting requirement, and the circumstances under which the extension may be terminated. The notice shall also include a Medi-Cal card or other evidence of entitlement to those services.

(c) Notwithstanding any other provision of this section, the department, in conformance with federal law, shall offer beneficiaries covered under subdivision (a) the option of remaining eligible for health care services provided in this chapter for an additional extension period of six months. Health services shall be continued in as automatic a manner as permitted by federal law, and without any unnecessary paperwork.

(d) During the initial extension period and any additional six-month extension period, the department, consistent with federal

law, may, whenever the department determines it to be cost-effective, elect to pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of the dependent child. If, during the additional six-month extension period, the department elects to pay health premiums and this coverage exists, the beneficiary may be given the opportunity to express his or her preference between continuing the Medi-Cal coverage or obtaining health insurance.

(e) During the additional six-month extension period, the department may impose a premium for the health insurance or other health coverage consistent with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) if the department determines that the imposition of a premium is cost-effective.

(f) The department shall adopt emergency regulations in order to comply with mandatory provisions of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) for extension of medical assistance. These regulations shall become effective immediately upon filing with the Secretary of State.

(g) This section shall become operative April 1, 1990.

SEC. 72. Section 14005.81 of the Welfare and Institutions Code is repealed.

SEC. 73. Section 14005.81 is added to the Welfare and Institutions Code, to read:

14005.81. (a) Effective October 1, 1998, in addition to the two six-month periods of transitional Medi-Cal benefits provided in Section 14005.8, the state shall fund and provide one additional 12-month period of transitional Medi-Cal to persons age 19 years and older who have received 12 months of transitional Medi-Cal under Section 14005.8 and who continue to meet the requirements applicable to the additional six-month extension period provided for in Section 14005.8. The benefits provided under this section shall commence on the day following the last day of receipt of benefits under Section 14005.8.

(b) In the case of an alien who has received 12 months of transitional Medi-Cal under Section 14005.8, the benefits provided under this section shall be limited to those benefits that would be available to that person under Section 14005.8.

(c) It is the intent of the Legislature that the department seek a mechanism for securing federal financial participation in connection with pregnancy-related benefits provided under this section.

SEC. 74. Section 14005.82 of the Welfare and Institutions Code is repealed.

SEC. 75. Section 14005.83 of the Welfare and Institutions Code is repealed.

SEC. 76. Section 14016.11 of the Welfare and Institutions Code is repealed.

SEC. 77. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal or aid to families with dependent children (AFDC) applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall personally attend a presentation at which the applicant or beneficiary is informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary or applicant attends this presentation.

(b) The health care options presentation described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, and telephone number of each primary care provider, by specialty, or clinic participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. The name, address, and telephone number of each specialist participating in each prepaid managed care health plan, pilot project, or fee-for-service case management provider option shall be made available by either contacting the health care options contractor or the prepaid managed care health plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot projects, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, who choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider contracting with the selected prepaid managed health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan or pilot project or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects

a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service managed care provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service managed care provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic that it has been selected or assigned. The managed care plan, pilot project, or fee-for-service

case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(l) In areas where there is no prepaid managed health care plan or pilot program which has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) “Applicant,” “beneficiary,” and “eligible applicant,” in the case of a family group, means any person with legal authority to make a choice on behalf of dependent family members.

(2) “Fee-for-service case management provider” means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) “Managed health care plan” and “managed care plan” mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) (1) Whenever a county welfare department notifies a public assistance recipient or Medi-Cal beneficiary that the recipient or beneficiary is losing Medi-Cal eligibility, the county shall include, in the notice to the recipient or beneficiary, notification that the loss of

eligibility shall also result in the recipient's or beneficiary's disenrollment from Medi-Cal managed care health or dental plans, if enrolled.

(2) (A) Whenever the department or the county welfare department processes a change in a public assistance recipient's or Medi-Cal beneficiary's residence or aid code that will result in the recipient's or beneficiary's disenrollment from the managed care health or dental plan in which they are currently enrolled, a written notice shall be given to the recipient or beneficiary.

(B) This paragraph shall become operative and the department shall commence sending the notices required under this paragraph on or before the expiration of 12 months after the effective date of this section.

(o) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 78. Section 14016.55 is added to the Welfare and Institutions Code, to read:

14016.55. (a) It is the intent of the Legislature that Medi-Cal beneficiaries who are required to enroll in a Medi-Cal managed care health plan make an informed choice that is not the result of confusion, lack of information, or understanding of the choices available to them.

(b) It is the intent of the Legislature that the department strive to increase the level of choice of Medi-Cal beneficiaries required to enroll in a Medi-Cal managed care health plan and that default rates be no greater than 20 percent in any participating county.

(c) In any county in which conversion to managed care plan enrollment has taken place and where the default rate, as defined in subdivision (e), is 20 percent or higher in two consecutive months occurring after conversion upon the effective date of this section, the department shall conduct a one-time survey of beneficiaries aimed at determining the reasons why beneficiaries fail to enroll into a managed care plan when required to do so by the department or its health care options contractor.

(d) The department shall submit the results of the survey to the appropriate legislative policy and budget committees within six months of completion, and implement a plan of correction intended to reduce the rate of beneficiary default. The plan of correction may include, but not be limited to, culturally appropriate outreach and education activities, including the use of community based organization.

(e) For purposes of this section, "default rate" refers to the rate of Medi-Cal beneficiaries defaulting into managed care health plan enrollment by virtue of their failure to make an election, as provided for in Section 14016.5.



SEC. 79. Section 14067 of the Welfare and Institutions Code is amended to read:

14067. (a) The department, in conjunction with the Managed Risk Medical Insurance Board, shall develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal and the Healthy Families Program of the Managed Risk Medical Insurance Board, subject to the requirements of federal law. In conducting this campaign, the department may seek input from, and contract with, various entities and programs that serve children, including, but not limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children to assist in the outreach, education, and application completion process.

(b) The outreach and education campaign shall be established and implemented as of February 18, 1998. An annual outreach plan shall be submitted to the Legislature by April 1 for each fiscal year. The plan shall address both the Medi-Cal program for children and the Healthy Families Program and, at a minimum, shall include the following:

(1) Specific milestones and objectives to be completed for the upcoming year and their anticipated cost.

(2) A general description of each strategy or method to be used for outreach.

(3) Geographic areas and special populations to be targeted, if any, and why the special targeting is needed.

(4) Coordination with other state or county education and outreach efforts.

(5) The results of previous year outreach efforts.

(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any such contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(d) The department, in conjunction with the Managed Risk Medical Insurance Board, may conduct pilot outreach and education projects through the allocation of grant funds or through a competitive process, to entities with experience in serving uninsured children, Medi-Cal beneficiaries, or in providing services to low-income families. The purpose of these pilot outreach and education projects will be to encourage the enrollment of children in the Healthy Families and Medi-Cal programs in underserved areas, or areas which may require special, focused outreach efforts

such as rural areas, areas with cultural and linguistic diversity, or areas that have low enrollment levels.

SEC. 80. Section 14093.88 is added to the Welfare and Institutions Code, to read:

14093.88. (a) There is hereby established in the State Treasury the Local Initiative Traditional Provider Loan Assistance Account, which, notwithstanding Section 13340 of the Government Code, is continuously appropriated to the department for the purposes of this section. The Controller shall deposit in the account any moneys appropriated in the annual Budget Act for this purpose.

(b) Moneys in the account established pursuant to subdivision (a) shall, except for any amount necessary to defray the administrative costs of the department in implementing this section, be used to make a loan to the Los Angeles County Health Care Authority (L.A. Care Health Plan) for the purposes specified in subdivision (c).

(c) (1) The L.A. Care Health Plan shall use moneys received pursuant to subdivision (b) in order to establish a pilot project to provide collateral to guarantee loans to traditional providers who serve large numbers of Medi-Cal recipients and who are under contract with the L.A. Care Health Plan to serve Medi-Cal recipients, in order to improve access by these providers to low-interest financing.

(2) The purpose of the pilot project is to assist traditional providers in their transition to managed care by improving access by these providers to low-interest loans which shall be used to upgrade facilities and operation capabilities to address managed care requirements.

(d) In reviewing the applications for loans to traditional providers, the L.A. Care Health Plan and the participating commercial bank shall consider, among other things, all of the following:

(1) The number of Medi-Cal managed care patients assigned to the provider.

(2) The provider's demonstrated commitment to serving Medi-Cal patients.

(3) The likelihood that the proposed project will result in improved quality of care for Medi-Cal managed care patients or the improved management and survivability of the provider, or both.

(4) The likelihood that the applicant could obtain low-interest loans through other loan programs.

(e) L.A. Care Health Plan shall ensure that each project funded by a loan under the pilot project established pursuant to subdivision (c) is evaluated and that the evaluation process includes the input of consumers, providers, and other health care experts, as appropriate.

(f) The L.A. Care Health Plan shall repay the loan made pursuant to subdivision (b) by January 1, 2002, including interest at the pooled money investment rate. Regardless of whether any providers default on loans guaranteed under this pilot project, if the L.A. Care Health

Plan fails to repay the loan in accordance with this subdivision, the department may offset any amount owed by the plan against any other amount due to the plan from the department.

(g) By January 1, 2001, the L.A. Care Health Plan shall submit to the department an evaluation of the pilot project, which shall include data on how funds were used by the plan and how the provision of loans under this project improved encounter-level data reporting by the plan under its contract with the department. The department shall establish criteria to be used by the plan in determining, pursuant to the evaluation, the success of the pilot project.

(h) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 81. Section 14100.7 of the Welfare and Institutions Code is amended to read:

14100.7. (a) Any Medi-Cal provider of incontinence supplies or medical supplies, or both, shall provide, to the department, a bond, or other security satisfactory to the department, of not less than twenty-five thousand dollars (\$25,000), pursuant to regulations adopted by the department.

(b) (1) After three years of continuous operation as a provider of incontinence supplies or medical supplies, or both, a Medi-Cal provider may apply to the department for an exemption from the requirements of subdivision (a).

(2) The department shall adopt regulations establishing conditions for the approval or denial of applications for exemption pursuant to paragraph (1).

(c) For purposes of this section, “incontinence supplies” and “medical supplies” mean items prescribed by a licensed practitioner to meet medical needs of the patient, and which are eligible for reimbursement pursuant to this chapter.

(d) Subdivisions (a), (b), and (c) do not apply to individuals who are licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

SEC. 82. Section 14100.8 is added to the Welfare and Institutions Code, to read:

14100.8. (a) For purposes of this section, “provider of home health agency services” means a home health agency that is licensed by the department under Section 1726 of the Health and Safety Code that meets the requirements for the medicaid program under Subpart A (commencing with Sec. 441.10) of Part 441 of Title 42 of the Code of Federal Regulations, as amended, that meets the requirements for the Medicare program under Part 484 (commencing with Sec. 481.1) and Part 489 (commencing with Sec. 489.1) of Title 42 of the Code of Federal Regulations, as amended, and that is enrolled as a provider in the Medi-Cal program. In the event



of inconsistent requirements between the medicaid and Medicare programs, medicaid requirements shall take precedence.

(b) Within 90 days after the effective date of a final federal regulation requiring that a provider of home health agency services must acquire a surety bond in order to participate in the medicaid or Medicare program, each provider of home health agency services shall obtain, and thereafter maintain, a surety bond meeting the requirements of the final federal regulation, as amended, as a condition of participation in the Medi-Cal program.

(c) Any entity that has applied to become a provider of home health agency services less than 90 days prior to the date that the final federal regulation described in subdivision (b) becomes effective shall submit a surety bond within 90 days of the effective date of the regulation.

(d) Failure of a provider of home health agency services to obtain and maintain a surety bond as required in this section shall result in denial or recoupment of Medi-Cal reimbursement for services provided during the period for which a surety bond should have been in effect.

(e) Failure of a provider of home health agency services to obtain and maintain a surety bond as required in this section shall result in automatic termination of the provider's participation in the Medi-Cal program.

SEC. 83. Section 14100.9 is added to the Welfare and Institutions Code, to read:

14100.9. (a) For purposes of this section, "provider of durable medical equipment" means any person or entity that furnishes medical equipment and medical supplies, meets state and local laws applicable to the furnishing of medical equipment and medical supplies, and that is enrolled as a provider in the Medi-Cal program.

(b) Within 90 days after the effective date of a final federal regulation requiring that a provider of durable medical equipment must acquire a surety bond in order to participate in the medicaid or Medicare program, each provider of durable medical equipment shall obtain, and thereafter maintain, a surety bond meeting the requirements of the final federal regulation, as amended, as a condition of participation in the Medi-Cal program.

(c) Any person or entity that has applied to become a provider of durable medical equipment less than 90 days prior to the date that the final federal regulation described in subdivision (b) becomes effective shall submit a surety bond within 90 days of the effective date of the regulation.

(d) Failure of a provider of durable medical equipment to obtain and maintain a surety bond as required in this section shall result in denial or recoupment of Medi-Cal reimbursement for services provided during the period for which a surety bond should have been in effect.



(e) Failure of a provider of durable medical equipment to obtain and maintain a surety bond as required in this section shall result in automatic termination of the provider's participation in the Medi-Cal program.

(f) Subdivisions (a), (b), (c), (d), and (e) do not apply to individuals who are licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

SEC. 84. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) "Single-source drug" means a drug that is produced and distributed under an original New Drug Application approved by the federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration under the provisions for an Abbreviated New Drug Application.

(b) "Best price" means the negotiated price, or the manufacturer's lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) "Equalization payment amount" means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract. The equalization payment amount shall be based on the difference between the manufacturer's direct catalog price charged to wholesalers and the manufacturer's best price, as defined in subdivision (b).

(d) "Manufacturer" means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the



packaging, repackaging, labeling, relabeling, and distribution of drugs.

(e) “Price escalator” means a mutually agreed upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(f) “Medi-Cal pharmacy costs” or “Medi-Cal drug costs” means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(g) “Medicaid rebate” means the rebate payment made by drug manufacturers pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(h) “State rebate” means any negotiated rebate under the Drug Discount Program in addition to the medicaid rebate.

(i) “Date of mailing” means the date that is evidenced by the postmark date by the United States Postal Service or other common mail carrier on the envelope.

(j) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 85. Section 14105.33 of the Welfare and Institutions Code is amended to read:

14105.33. (a) The department may enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category, and shall maintain a list of those drugs for which contracts have been executed.

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer’s best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, including supporting utilization data from the department’s prescription drug paid claims tapes within 30 days of receipt of the Health Care Financing Administration’s file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Health Care Financing Administration’s Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department’s mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable

amount until final resolution of the dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

(2) The department shall provide for an annual audit of utilization data used to calculate the equalization amount to verify the accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

(A) Health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract under Section 1396b(m) of Title 42 of the United States Code.

(B) Capitated plans that include a prescription drug benefit in the capitated rate, and that have negotiated contracts for rebates or discounts with manufacturers.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of therapeutic agents, the department shall ensure that there is representation on the list of contract drugs in all major therapeutic categories. Except as provided in subdivision (a) of Section 14105.35, the department shall not be required to contract with all manufacturers who negotiate for a contract in a particular category. The department shall ensure that there is sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) (1) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(2) The department shall make every attempt to complete the initial contracting process for each major therapeutic category by January 1, 1999.

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines



necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug which is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(3) In order to expedite implementation of paragraph (1), the requirements of Sections 14105.37, 14105.38, subdivisions (a), (c), (e), and (f) of Sections 14105.39, 14105.4, and 14105.405 are waived for the purposes of this section until January 1, 1994.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews.

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates. The interest shall not apply to any prior period adjustments of unit rebate amounts or department utilization adjustments.

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

(l) Interest pursuant to subdivision (k) shall begin accruing 38 calendar days from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(m) Except as specified in subdivision (n), interest rates and calculations pursuant to subdivision (k) for medicaid rebates and state rebates shall be identical and shall be determined by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations.

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant to subdivision (k) shall be as specified in subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the



date of mailing of the invoice, including utilization data sent to manufacturers.

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

(q) The department shall direct the state's fiscal intermediary to remove prior authorization requirements imposed pursuant to subdivision (o) and notify providers within 60 days after payment by the manufacturer of the rebate, including interest. If a contract was in place at the time the manufacturers' drugs were placed on prior authorization, removal of prior authorization requirements shall be contingent upon good faith negotiations and a signed contract with the department.

(r) A beneficiary may obtain drugs placed on prior authorization pursuant to subdivision (o) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug when its manufacturer is placed on prior authorization status. Additionally, the department shall have received a claim for the drug with a date of service that is within 100 days prior to the date the manufacturer was placed on prior authorization.

(s) A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same drug.

(t) Drugs covered pursuant to Sections 14105.43 and 14133.2 shall not be subject to prior authorization pursuant to subdivision (o), and any other drug may be exempted from prior authorization by the department if the director determines that an essential need exists for that drug, and there are no other drugs currently available without prior authorization that meet that need.

(u) It is the intent of the Legislature in enacting subdivisions (k) to (t), inclusive, that the department and manufacturers shall cooperate and make every effort to resolve rebate payment disputes within 90 days of notification by the manufacturer to the department of a dispute in the calculation of rebate payments.

(v) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 86. Section 14105.35 of the Welfare and Institutions Code is amended to read:

14105.35. (a) (1) On and after July 1, 1990, drugs included on the Medi-Cal drug formulary shall be included on the list of contract drugs until the department and the manufacturer have concluded

contract negotiations or the department suspends the drug from the list of contract drugs pursuant to the provisions of this subdivision.

The department shall, in writing, invite any manufacturer with single-source drug products on the formulary as of July 1, 1990, to enter into negotiations relative to the retention of its drug or drugs. As to the issue of cost, the department shall accept the manufacturer's best price as sufficient for purposes of entering into a contract to retain the drug or drugs on the list of contract drugs.

If the department and a manufacturer enter into a contract for retention of a drug or drugs on the list of contract drugs, the drug or drugs shall be retained on the list of contract drugs for the effective term of the contract.

If a manufacturer refuses to enter into negotiations with the department pursuant to this subdivision, or if after 30 days of negotiation, the manufacturer has not agreed to execute a contract for a drug at the manufacturer's best price, the department may suspend from the list of contract drugs the manufacturer's single-source drug in question for a period of at least 180 days. The department shall lift the suspension upon execution of a contract for that drug. Consistent with the provisions of this section, the department shall delete the Medi-Cal drug formulary specified in paragraphs (b), (c), (d), and (e) of Section 59999 of Title 22 of the California Code of Regulations.

(2) On and after July 1, 1990, the director may retain a drug on the Medi-Cal list of contract drugs even if no contract is executed with a manufacturer, if the director determines that an essential need exists for that drug, and there are no other drugs currently on the formulary that meet that need.

(3) The director may delete a drug from the list of contract drugs if the director determines that the drug presents problems of safety or misuse. The director's decision as to safety shall be based upon published medical literature, and the director's decision as to misuse shall be based on published medical literature and claims data supplied by the fiscal intermediary.

(b) Any reference to the Medi-Cal drug formulary by statute or regulation shall be construed as referring to the list of contract drugs.

(c) (1) Any drug in the process of being added to the formulary by contract agreement pursuant to Section 14105.3, executed prior to the effective date of this section, shall be added to the list of contract drugs.

(2) Contracts pursuant to Section 14105.3 executed prior to January 1, 1991, shall be considered to be contracts executed pursuant to Section 14105.33, and the department shall exempt the drugs included in these contracts from the initial therapeutic category review in which they would normally be considered.

(3) Nothing in this section shall be construed to require the department to discontinue negotiations into which it has entered



with any manufacturer as of the effective date of this section. Contracts entered into as a result of these negotiations shall be exempt from the initial therapeutic category review in which they would normally be considered.

(d) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 87. Section 14105.37 of the Welfare and Institutions Code is amended to read:

14105.37. (a) The department shall notify each manufacturer of drugs in therapeutic categories selected pursuant to Section 14105.33 of the provisions of Sections 14105.31 to 14105.42, inclusive.

(b) If, within 45 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may suspend or delete from the list of contract drugs, or refuse to consider for addition, drugs of that manufacturer in the selected therapeutic categories.

(c) If, after 150 days from the initial notification, a contract is not executed for a drug currently on the list of contract drugs, the department may suspend or delete the drug from the list of contract drugs.

(d) If, within 150 days from the initial notification, a contract is executed for a drug currently on the list of contract drugs, the department shall retain the drug on the list of contract drugs.

(e) If, within 150 days from the date of the initial notification, a contract is executed for a drug not currently on the list of contract drugs, the department shall add the drug to the list of contract drugs.

(f) The department shall terminate all negotiations 150 days after the initial notification.

(g) The department may suspend or delete any drug from the list of contract drugs at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

(h) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 shall be subject to prior authorization, as if that drug were not on the list of contract drugs.

(i) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 for at least 12 months may be deleted from the list of contract drugs in accordance with the provisions of Section 14105.38.

(j) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 88. Section 14105.38 of the Welfare and Institutions Code is amended to read:

14105.38. (a) (1) In the event the department determines a drug should be deleted from the list of contract drugs, the

department shall conduct a public hearing, as provided in this section, to receive comment on the impact of removing the drug.

(2) (A) The department shall provide written notice 30 days prior to the hearing.

(B) The department shall send the notice required by this subdivision to the manufacturer of the drug proposed to be deleted and to organizations representing Medi-Cal beneficiaries.

(b) (1) The hearing panel shall consist of the Chief, Medi-Cal Drug Discount Program, who shall serve as chair, and the Medi-Cal Contract Drug Advisory Committee.

(2) The hearing shall be recorded and transcribed, and the transcript available for public review.

(3) Subsequent to hearing all public comment, and within 30 days of the hearing, each panel member shall submit a recommendation regarding deletion of the drug and the reason for the recommendation to the director.

(c) The director shall consider public comments provided at the hearing and the recommendations of each panel member in determining whether to delete the drug.

(d) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 89. Section 14105.39 of the Welfare and Institutions Code is amended to read:

14105.39. (a) (1) A manufacturer of a new single-source drug may request inclusion of its drug on the list of contract drugs pursuant to Section 14105.33 provided all of the following conditions are met:

(A) The request is made within 12 months of approval for marketing by the federal Food and Drug Administration.

(B) The manufacturer agrees to negotiate a contract with the department to provide the drug at the manufacturer's best price.

(C) (i) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(ii) Notwithstanding clause (i), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(I) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(II) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(D) The department had concluded contracting for the therapeutic category in which the drug is included prior to approval of the drug by the federal Food and Drug Administration.

(2) Within 90 days from receipt of the request, the department shall evaluate the request using the criteria identified in subdivision (d), and shall submit the drug to the Medi-Cal Contract Drug Advisory Committee.

(b) Any petition for the addition to or deletion of a drug to the Medi-Cal drug formulary submitted prior to July 31, 1990, shall be deemed to be denied. A manufacturer who has submitted a petition deemed denied may request inclusion of that drug on the list of contract drugs provided all of the following conditions are met:

(1) The manufacturer agrees to negotiate for a contract with the department to provide the drug at the manufacturer's best price.

(2) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(3) The manufacturer submits the request to the department prior to October 1, 1990.

(c) Any new drug designated as having an important therapeutic gain and approved for marketing by the federal Food and Drug Administration on or after July 31, 1990, shall immediately be included on the list of contract drugs for a period of three years provided that all of the following conditions are met:

(1) The manufacturer offers the department its best price.

(2) The drug is typically administered in an outpatient setting.

(3) The drug is prescribed only for the indications and usage specified in the federal Food and Drug Administration approved labeling.

(4) The drug is determined by the director to be safe, relative to other drugs in the same therapeutic category on the list of contract drugs.

(d) (1) To ensure that the health needs of Medi-Cal beneficiaries are met consistent with the intent of this chapter, the department shall, when evaluating a decision to execute a contract, and when evaluating drugs for retention on, addition to, or deletion from, the list of contract drugs, use all of the following criteria:

(A) The safety of the drug.

(B) The effectiveness of the drug.

(C) The essential need for the drug.

(D) The potential for misuse of the drug.

(E) The cost of the drug.

(2) The deficiency of a drug when measured by one of these criteria may be sufficient to support a decision that the drug should not be added or retained, or should be deleted from the list. However, the superiority of a drug under one criterion may be sufficient to warrant the addition or retention of the drug, notwithstanding a deficiency in another criterion.

(e) (1) A manufacturer of single-source drugs denied a contract pursuant to this section or Section 14105.33 or 14105.37, may file an

appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) Within 30 calendar days of the manufacturer's appeal, the director shall request a recommendation regarding the appeal from the Medi-Cal Contract Drug Advisory Committee. The committee shall provide its recommendation in writing, within 30 calendar days of the director's request.

(3) The director shall issue a final decision on the appeal within 30 calendar days of the recommendation.

(f) Deletions made to the list of contract drugs, including those made pursuant to Section 14105.37, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(g) Changes made to the list of contract drugs under this or any other section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(h) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 90. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 35 of Chapter 197 of the Statutes of 1996, is amended to read:

14105.4. (a) The director shall appoint a Medi-Cal Contract Drug Advisory Committee for the purpose of providing scientific and medical analysis on drugs contained on the list of contract drugs. The duties of the committee shall be as follows:

(1) To review drugs in the Medi-Cal list of contract drugs and make written recommendations to the director as to the addition of any drug or the deletion of any drug from the list. These recommendations shall be in accordance with subdivision (d) of Section 14105.39.

(2) To review and report in writing to the director as to the comparative therapeutic effect of drugs in accordance with Section 14053.5.

(3) To prepare a fair, impartial, and independent recommendation in writing, regarding appeals from manufacturers made pursuant to subdivision (e) of Section 14105.39.

(b) The committee shall consist of at least one representative from each of the following groups:

- (1) Physicians.
- (2) Pharmacists.
- (3) Schools of pharmacy or pharmacologists.
- (4) Medi-Cal beneficiaries.

(c) Members of the committee shall be reimbursed for necessary travel and other expenses incurred in the performance of official committee duties.

(d) In order to provide sufficient scientific information and analysis in the therapeutic categories under review, the director may replace a representative if required for specific expertise.

(e) The director shall notify the committee of the decisions made on the recommendations.

(f) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 91. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 36 of Chapter 197 of the Statutes of 1996, is amended to read:

14105.4. (a) The department shall schedule and conduct a public regulatory hearing to consider the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary five working days subsequent to the Medical Therapeutic and Drug Advisory Committee meeting which shall meet at least every four months. The public hearing may consist of written testimony only, and the hearing record shall be closed at the end of the public hearing.

(b) The department shall make available 45 days prior to the public hearing the department's estimate of any anticipated costs or savings to the state from adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary.

(c) Whenever the department accepts a completed petition to add a drug product to the Medi-Cal drug formulary and it is not processed pursuant to Section 14105.9, it shall be scheduled for review at the next regularly scheduled Medical Therapeutic and Drug Advisory Committee meeting and public regulatory hearing, unless the meeting and hearing are scheduled to occur within 120 days, in which case the drug product may be scheduled for the following hearing.

(d) The director shall issue a final decision regarding the drug product and shall submit any regulation adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary to the Office of Administrative Law, along with the completed rulemaking record, within seven months after the hearing prescribed in subdivision (a). This section shall not, however, be construed in a manner which results in the disapproval or invalidation of a regulation for failure to comply with the time frames prescribed in this subdivision and subdivisions (a) and (c).

(e) (1) Except as provided in paragraph (2), the criteria used by the department in deciding whether a drug product shall be added to or deleted from the formulary shall be limited to the criteria adopted as department regulations. The criteria shall be specific and unambiguous.



(2) Notwithstanding paragraph (1), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(A) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(B) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(f) Departmental requests for information from persons filing drug petitions to which this section applies shall be specific and unambiguous and shall be made solely for the purpose of addressing the criteria utilized in accordance with subdivision (e).

(g) All published studies received by the department pursuant to a drug petition prior to the close of the public regulatory hearing record shall be accepted and considered by the department.

(h) Whenever the director decides to reject a petition to add a drug product to, or delete a drug product from, the formulary, the director shall notify the petitioner directly and in writing indicating the reason and specifying the criteria utilized in reaching the decision.

(i) The department shall accept a petition for a drug that has been rejected by the director upon the submission of another complete petition containing substantial new information that addresses the reason or reasons for rejection stated by the director pursuant to subdivision (h). Any petition accepted pursuant to this subdivision shall be processed in accordance with subdivision (c), or Section 14105.9, whichever is applicable.

(j) This section shall become operative on January 1, 2000.

SEC. 92. Section 14105.405 of the Welfare and Institutions Code is amended to read:

14105.405. (a) A Medi-Cal beneficiary, within 90 days of receipt of the director's notice to beneficiaries pursuant to subdivision (g) of Section 14105.33, informing them of the decision to delete or suspend a drug from the list of contract drugs, may request a fair hearing pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(b) Any beneficiary filing a fair hearing request regarding the deletion or suspension of a drug from the formulary shall be granted a treatment authorization request for that drug until a final decision is adopted by the director. Should the beneficiary seek judicial review of the director's decision, a treatment authorization request shall be granted for that drug until a final decision is issued by the court.

(c) (1) Any Medi-Cal beneficiary, within one year of the director's decision pursuant to Section 10959, may file a petition with the superior court, under the provisions of Section 1094.5 of the Code

of Civil Procedure, praying for a review of both the legal and factual basis for the director's decision.

(2) The director shall be the sole respondent in these proceedings.

(d) Any Medi-Cal beneficiary injured as a result of being denied a drug which is determined to be medically necessary may sue for injunctive or declaratory relief to review the director's decision to delete or suspend a drug from the list of contract drugs.

(e) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 93. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 38 of Chapter 197 of the Statutes of 1996, is amended to read:

14105.41. (a) Moneys accruing to the department from contracts executed pursuant to Section 14105.33 shall be deposited in the Health Care Deposit Fund, and shall be subject to appropriation by the Legislature.

(b) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 94. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 39 of Chapter 197 of the Statutes of 1996, is amended to read:

14105.41. (a) For the purpose of adding drugs to, or deleting drugs from, the Medi-Cal drug formulary as described in Section 14105.4, whether pursuant to a petition or by the department independent of a petition, all of the requirements of the Administrative Procedure Act contained in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code shall be applicable except that the requirements of subdivision (a) of Section 11340.7 and subdivision (a) of Section 11346.9 of the Government Code shall be deemed to have been complied with if the department does all of the following:

(1) Upon receipt of a petition requesting the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary, the department shall notify the petitioner directly and in writing of the receipt of the petition and shall, within 30 days, either return the petition as incomplete or schedule the petition for public hearing, unless the public hearing is not required pursuant to Section 14105.9.

(2) Notifies each petitioner directly and in writing of its decision regarding the addition of a drug product to, or deletion of a drug product from, the formulary and shall state the reason or reasons for its decision and the specific regulatory criteria that are the basis of the department's decision.

(3) Prepares and submits to the Office of Administrative Law with the adopted regulation all of the following for each drug which the

department has decided to add to, or delete from, the Medi-Cal drug formulary:

(A) A brief summary of the comments submitted. For the purpose of this section, "comments" shall mean the major points raised in testimony which specifically address the regulatory criteria upon which the department is authorized, pursuant to subdivision (e) of Section 14105.4, to base a decision to add or delete a drug from the formulary.

(B) The recommendation of the Medical Therapeutic and Drug Advisory Committee.

(C) The decision of the department.

(D) A statement of the reason and the specific regulatory criteria that are the basis of the department's decision.

(b) Any additional information provided to the department during the posting of revisions to the proposed regulation shall be responded to by the department directly and in writing to the originator. That response shall notify the originator whether the additional information has resulted in a changed decision.

(c) For the purpose of review by the court, if any, and review and approval by the Office of Administrative Law of changes to the Medi-Cal drug formulary adopted by the department, each drug added to, or deleted from, the formulary shall be considered to be a separate regulation and shall be severable from all other additions or deletions of drugs contained in the rulemaking file.

(d) This section shall be applicable to any Medi-Cal drug formulary regulation package filed with the Office of Administrative Law on or after January 1, 2000.

(e) This section shall become operative on January 1, 2000.

SEC. 95. Section 14105.42 of the Welfare and Institutions Code, as amended by Chapter 690 of the Statutes of 1997, is amended to read:

14105.42. (a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.

(b) The department shall provide the following data to the Legislature and to the State Auditor by January 1, 1991, and every six months thereafter:

(1) The number of drug treatment authorization requests (TAR) received by facsimile, by secondary answering system and in person for each therapeutic category.

(2) The number of drug TARS requested, approved, denied, and returned.

(3) The length of time between the TAR request and the decision, specified by type of communication such as telephone or facsimile if available.

(4) For denied TARS, the number of fair hearings requested, approved, denied and pending.

(5) The numbers of providers who were unable to submit a request or made multiple attempts because of faulty or unavailable lines of communication, if available.

(6) The numbers of complaints made by beneficiaries and providers relating to difficulty or inability to obtain a TAR response.

(7) The status of the enhancements to the TAR process specified in Section 21 of Chapter 457 of the Statutes of 1990.

(8) The number of calls on the TAR line which are not getting through.

(c) Until January 1, 2000, or the date of the report specified in subdivision (f), whichever is earlier, the State Auditor shall prepare a report by February 1, 1991, and every six months thereafter providing a summary and analysis of the data specified in subdivision (b), and a comparative analysis of changes in the TAR process using June 1, 1990, as a base. The analysis shall include a measure of increased or decreased ability to contact the department and receive a response in a shorter or greater period of time.

(d) The Bureau of State Audits shall prepare a report by January 1, 1998, on the drug program management techniques of the drug contracting program, and the comparability of the program to other private sector third-party payers. In completing its report the bureau may consult with the department, prescribing physicians, pharmacists, drug manufacturers, representatives of beneficiaries, and others as the bureau sees fit.

(e) The department shall report to the Legislature, through the annual budget process, on the cost-effectiveness of contracts executed pursuant to Section 14105.33.

(f) The Joint Legislative Audit Committee may review and report on the requirements imposed on the State Auditor by subdivision (c) on or before January 1, 2000.

(g) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2000, deletes or extends that date.

SEC. 96. Section 14105.91 of the Welfare and Institutions Code is amended to read:

14105.91. The department may add a drug to the formulary which is a different dosage form, or strength of a drug product which is listed in the formulary without review by the Medical Therapeutics and Drug Advisory Committee and the addition shall be deemed to comply with the requirements of the California Administrative Procedures Act.

This section shall become operative on January 1, 2000.

SEC. 97. Section 14105.915 of the Welfare and Institutions Code is amended to read:

14105.915. The department may remove any drug from the formulary at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

This section shall become operative on January 1, 2000.

SEC. 98. Section 14105.916 of the Welfare and Institutions Code is amended to read:

14105.916. Notwithstanding any other provision of law, on and after January 1, 2000, drugs on the Medi-Cal list of contract drugs shall become the Medi-Cal drug formulary.

SEC. 99. Section 14124.70 of the Welfare and Institutions Code is amended to read:

14124.70. As used in this article:

(a) "Carrier" includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) "Beneficiary" means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary's guardian, conservator or other personal representative, his estate or survivors.

(c) "Reasonable value of benefits" means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

SEC. 100. Section 14124.72 of the Welfare and Institutions Code is amended to read:

14124.72. (a) Where an action is brought by the director pursuant to Section 14124.71, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section 14124.71.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's right to recover from that party the reasonable value of the benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d).

(d) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the reasonable value of benefits provided to the beneficiary under the Medi-Cal program less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the reasonable value of benefits so provided to the full amount of the judgment, award, or settlement.

SEC. 101. Section 14124.74 of the Welfare and Institutions Code is amended to read:

14124.74. In the event of judgment or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of the settlement, judgment, or award the reasonable value of additional benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d) of Section 14124.72, and as a second lien, the amount of any claims, pursuant to Section 14019.3, owed to a provider, as provided in Section 14124.791.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of these expenses and attorney's fees, the court or agency shall first apply out of the balance of the judgment or award an amount sufficient to reimburse the director the full amount of the reasonable value of benefits provided



on behalf of the beneficiary under the Medi-Cal program, and then an amount sufficient to reimburse a provider who has filed a lien for any claims for services rendered to the beneficiary, as provided under Section 14124.791.

SEC. 102. Section 14124.75 of the Welfare and Institutions Code is amended to read:

14124.75. The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the reasonable value of additional benefits provided arising out of the same cause of action or claim provided on behalf of the beneficiary under the Medi-Cal Program, where such benefits were provided or became payable subsequent to the original order.

SEC. 103. Section 14124.78 of the Welfare and Institutions Code is amended to read:

14124.78. Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the director's claim for reimbursement of the reasonable value of benefits provided and any lien filed pursuant thereto, but in no event shall the director's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

SEC. 104. Section 14132.44 of the Welfare and Institutions Code is amended to read:

14132.44. (a) Targeted case management (TCM), pursuant to Section 1915(g) of the Social Security Act as amended by Public Law 99-272 (42 U.S.C. Sec. 1396n(g)), shall be covered as a benefit, effective January 1, 1995. Nothing in this section shall be construed to require any local governmental agency to implement TCM.

(b) A TCM provider furnishing TCM services shall be a local governmental agency under contract with the department to provide TCM services. Local educational agencies shall not be providers of case management services under this section.

(c) A TCM provider may contract with a nongovernmental entity or the University of California, or both, to provide TCM services on its behalf under the conditions specified by the department in regulations.

(d) Each TCM provider shall have all of the following:

(1) Established procedures for performance monitoring.

(2) A countywide system to prevent duplication of services and to ensure coordination and continuity of care among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

(3) A fee mechanism effective January 1, 1995, specific to TCM services provided, which may vary by program.

(e) A TCM service provider, a nongovernmental entity or the University of California, or both, under contract with a TCM provider may provide TCM services to one or all of the following groups of Medi-Cal beneficiaries, which shall be defined in regulation:

- (1) High-risk persons.
- (2) Persons who have language or other comprehension barriers.
- (3) Persons on probation.
- (4) Persons who have exhibited an inability to handle personal, medical, or other affairs.
- (5) Persons abusing alcohol or drugs, or both.
- (6) Adults at risk of institutionalization.
- (7) Adults at risk of abuse or neglect.

(f) (1) A local governmental agency that elects to provide TCM services to the groups specified in subdivision (e) shall, for each fiscal year, for the purpose of obtaining federal medicaid matching funds, submit an annual cost report as prescribed by the department that certifies all of the following:

(A) The availability and expenditure of 100 percent of the nonfederal share for the provision of TCM services from the local governmental agency's general fund or from any other funds allowed under federal law and regulation.

(B) The amount of funds expended on allowable TCM services.

(C) Its expenditures represent costs that are eligible for federal financial participation.

(D) The costs reflected in the annual cost reports used to determine TCM rates are developed in compliance with the definitions contained in the Office of Management and Budget (OMB) Circular A-87.

(E) Case management services provided in accordance with Section 1396n(g) of Title 42 of the United States Code will not duplicate case management services provided under any home- and community-based services waiver.

(F) Claims for providing case management services pursuant to this section will not duplicate claims made to public agencies or private entities under other program authorities for the same purposes.

(G) The requirements of subdivision (d) have been met.

(2) The department shall deny any claim if it determines that any certification required by this subdivision is not adequately supported for purposes of federal financial participation.

(g) Only a local governmental agency may submit TCM service claims to the department for the performance of TCM services.

(h) During the period from January 1, 1995, through June 30, 1995, TCM services shall be reimbursed according to the interim mechanism developed by the state and the Health Care Financing Administration, which is reflected in the document entitled "Agreement Between the Health Care Financing Administration

and the State of California, Department of Health Services.” For the 1995–96 fiscal year, the department shall establish an initial rate of reimbursement. Effective July 1, 1996, and thereafter, TCM services shall be reimbursed in accordance with regulations that shall be adopted by the department.

(i) The department, in consultation with local governmental agencies, and consistent with federal regulations, and the State Medicaid Manual of the Department of Health and Human Services, Health Care Financing Administration, shall adopt regulations that define TCM services, establish the standards under which TCM services qualify as a Medi-Cal reimbursable service, prescribe the methodology for determining the rate of reimbursement, and establish a claims submission and processing system and method to certify local matching expenditures.

(j) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3) from any federal audit disallowance and interest resulting from payments made by the federal medicaid program as reimbursement for claims for providing TCM services pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any local governmental agency has received reimbursement for TCM services, the department shall recoup from the local governmental agency that submitted that disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraphs (1) and (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the local governmental agency has received reimbursement for TCM services performed by a nongovernmental entity or the University of California, or both, under contract with, and on behalf of, the participating local governmental agency, the department shall be held harmless by that particular local governmental agency for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(k) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for each local



governmental agency, except as required by this section or as may be required by federal law.

(l) TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by TCM providers, and their subcontractors, shall be defined in regulation, and shall include at least one of the following:

- (1) Assessment.
- (2) Plan development.
- (3) Linkage and consultation.
- (4) Assistance in accessing services.
- (5) Periodic review.
- (6) Crisis assistance planning.

(m) (1) Each local government agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of services described in this section under the Medi-Cal program. The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to $33\frac{1}{3}$ percent of the amounts that have been made available under this section, but in no case shall this contribution exceed twenty million dollars (\$20,000,000) in a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.47. Beginning with the 1994–95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues, and shall be deposited in the Targeted Case Management Claiming Fund, which is hereby created, for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated, notwithstanding Section 13340 of the Government Code, to the department for the support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each local governmental agency from the state, not related to payments required to be made pursuant to this section, in order to recoup these funds for the Targeted Case Management Claiming Fund.

(3) This subdivision shall only apply to claims approved for the 1994–95 to 1997–98 fiscal years, inclusive.

(n) As a condition of participation and in consideration of the joint effort of the local governmental agencies and the department in implementing this section and the ongoing need of local governmental agencies to receive technical support from the department, as well as assistance in claims processing and program monitoring, the local governmental agencies shall cover the costs of the administrative activities performed by the department. Each local governmental agency shall annually pay a portion of the total costs of administrative activities performed by the department through a mechanism agreed to by the department and the local governmental agencies, or if no agreement is reached by August 1 of each year, directly to the state. The department shall determine and report the staffing requirements upon which projected costs will be based. Projected costs shall include the anticipated salaries, benefits, and operating expenses necessary to administer targeted case management.

(o) For the purposes of this section a “local governmental agency” means a county or chartered city.

SEC. 105. Section 14132.47 of the Welfare and Institutions Code is amended to read:

14132.47. (a) It is the intent of the Legislature to provide local governmental agencies the choice of participating in either or both of the Targeted Case Management (TCM) and Administrative Claiming process programs at their option, subject to the requirements of this section and Section 14132.44.

(b) The department may contract with each participating local governmental agency or each local educational consortium to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program, pursuant to Section 1396b(a) of Title 42 of the United States Code, Section 1903a of the federal Social Security Act, and this activity shall be known as the Administrative Claiming process.

(c) (1) As a condition for participation in the Administrative Claiming process, each participating local governmental agency or each local educational consortium shall, for the purpose of claiming federal medicaid matching funds, enter into a contract with the department and shall certify to the department the amount of local governmental agency or each local educational consortium general funds or any other funds allowed under federal law and regulation expended on the allowable administrative activities.

(2) The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(d) Each participating local governmental agency or local educational consortium may subcontract with nongovernmental entities to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal

program under the conditions specified by the department in regulations.

(e) Each Administrative Claiming process contract shall include a requirement that each participating local governmental agency or each local educational consortium submit a claiming plan in a manner that shall be prescribed by the department in regulations, developed in consultation with local governmental agencies.

(f) The department shall require that each participating local governmental agency or each local educational consortium certify to the department both of the following:

(1) The availability and expenditure of 100 percent of the nonfederal share of the cost of performing Administrative Claiming process activities. The funds expended for this purpose shall be from the local governmental agency's general fund or the general funds of local educational agencies or from any other funds allowed under federal law and regulation.

(2) In each fiscal year that its expenditures represent costs that are eligible for federal financial participation for that fiscal year. The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(g) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3), from any federal audit disallowance and interest resulting from payments made to a participating local governmental agency or local educational consortium pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any participating local governmental agency or local educational consortium has received reimbursement for Administrative Claiming process activities, the department shall recoup from the local governmental agency or local educational consortium that submitted the disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed administrative activity or claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraph (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the participating local governmental agency or local educational consortium has received reimbursement for Administrative Claiming process activities performed by a nongovernmental entity under contract with, and on behalf of, the



participating local governmental agency or local educational consortium, the department shall be held harmless by that particular participating local governmental agency or local educational consortium for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(h) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for any participating local governmental agency or local educational consortium, except as required by this section or as may be required by federal law.

(i) The department shall deny any claim from a participating local governmental agency or local educational consortium if the department determines that the claim is not adequately supported in accordance with criteria established pursuant to this subdivision and implementing regulations before it forwards such a claim for reimbursement to the federal medicaid program. In consultation with local government agencies and local educational consortia, the department shall adopt regulations that prescribe the requirements for the submission and payment of claims for administrative activities performed by each participating local governmental agency and local educational consortium.

(j) Administrative activities shall be those determined by the department to be necessary for the proper and efficient administration of the state's medicaid plan and shall be defined in regulation.

(k) If the department denies any claim submitted under this section, the affected participating local governmental agency or local educational consortium may, within 30 days after receipt of written notice of the denial, request that the department reconsider its action. The participating local governmental agency or local educational consortium may request a meeting with the director or his or her designee within 30 days to present its concerns to the department after the request is filed. If the director or his or her designee cannot meet, the department shall respond in writing indicating the specific reasons for which the claim is out of compliance to the participating local governmental agency or local educational consortium in response to its appeal. Thereafter, the decision of the director shall be final.

(l) Participating local governmental agencies or local educational consortium may claim the actual costs of nonemergency, nonmedical transportation of Medi-Cal eligibles to Medi-Cal covered services, under guidelines established by the department, to the extent that these costs are actually borne by the participating local governmental agency or local educational consortium. A local educational consortium may only claim for nonemergency, nonmedical transportation of Medi-Cal eligibles for Medi-Cal



covered services, through the Medi-Cal administrative activities program. Medi-Cal medical transportation services shall be claimed under the local educational agency Medi-Cal billing option, pursuant to Section 14132.06.

(m) (1) Each participating local governmental agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of administrative activities described in this section under the Medi-Cal program. The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to $33\frac{1}{3}$ percent of amounts made available under this section, but in no case shall the contribution exceed twenty million dollars (\$20,000,000) a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.44. Beginning with the 1994–95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues and shall be deposited in the Administrative Claiming Fund for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated to the department for support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each participating local governmental agency from the state, not related to payments required to be made pursuant to this section in order to recoup these funds for the Administrative Claiming Fund.

(3) This subdivision shall only apply to claims approved for the 1994–95 to 1997–98 fiscal years, inclusive.

(n) As a condition of participation in the Administrative Claiming process and in recognition of revenue generated to each participating local governmental agency and each local educational consortium in the Administrative Claiming process, each participating local governmental agency and each local educational consortium shall pay an annual participation fee through a mechanism agreed to by the state and local governmental agencies and local educational consortia, or, if no agreement is reached by August 1 of each year, directly to the state. The participation fee shall be used to cover the cost of administering the Administrative

Claiming process, including, but not limited to, claims processing, technical assistance, and monitoring. The department shall determine and report staffing requirements upon which projected costs will be based. The amount of the participation fee shall be based upon the anticipated salaries, benefits, and operating expenses, to administer the Administrative Claiming process and other costs related to that process.

(o) For the purposes of this section “participating local governmental agency” means a county or chartered city under contract with the department pursuant to subdivision (b).

(p) For purposes of this section, “local educational agency” means a local educational agency, as defined in subdivision (h) of Section 14132.06, that participates under the Administrative Claiming process as a subcontractor to the local educational consortium in its service region.

(q) (1) For purposes of this section, “local educational consortium” means a local agency that is one of the service regions of the California County Superintendent Educational Services Association.

(2) Each local educational consortium shall contract with the department pursuant to paragraph (1) of subdivision (c).

(r) (1) Each participating local educational consortium shall be responsible for the local educational agencies in its service region that participate in the Administrative Claiming process. This responsibility includes, but is not limited to, the preparation and submission of all administrative claiming plans, training of local educational agency staff, overseeing the local educational agency time survey process, and the submission of detailed quarterly invoices on behalf of any participating local educational agency.

(2) Each participating local educational consortium shall ensure local educational agency compliance with all requirements of the Administrative Claiming process established for local governmental agencies.

(3) Ninety days prior to the initial participation in the Administrative Claiming process, each local educational consortium shall notify the department of its intent to participate in the process, and shall identify each local educational agency that will be participating as its subcontractor.

(s) (1) Each local educational agency that elects to participate in the Administrative Claiming process shall submit claims through its local educational consortium or through the local governmental agency, but not both.

(2) Each local educational agency participating as a subcontractor to a local educational consortium shall comply with all requirements of the Administrative Claiming process established for local governmental agencies.

(t) For the purposes of this section, a “nongovernmental entity” does not include an entity or person administered by, affiliated with, or employed by a participating local governmental agency or a local educational consortium.

(u) The requirements of subdivision (m) shall not apply to claims for administrative activities, pursuant to the Administrative Claiming process, performed by public health programs administered by the state.

(v) A participating local governmental agency or a local educational consortium may charge an administrative fee to any entity claiming Administrative Claiming through that agency.

(w) The department shall continue to administer the Administrative Claiming process in conformity with federal requirements.

(x) The department shall provide technical assistance to all participating local governmental agencies and local educational consortia in order to maximize federal financial participation in the Administrative Claiming process.

(y) This section shall be applicable to Administrative Claiming process activities performed, and to moneys paid to participating local governmental agencies and to local educational consortia in the 1998-99 fiscal year and thereafter for those activities, in the 1994-95 fiscal year and thereafter.

SEC. 106. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, “telemedicine” and “interactive” are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the

patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

(f) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2001, deletes or extends that date.

SEC. 107. The Legislature finds and declares as follows:

(a) Article 4.05 (commencing with Section 14139.05) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code (hereafter Article 4.05) defines a strong role for consumers of long-term care, and gives local communities the opportunity to define a long-term care system to meet their needs.

(b) In accordance with Article 4.5 (commencing with Section 14145) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, local organizing groups (LOGs) in at least seven counties have undertaken planning for a suitable long-term care system, and these groups have encountered numerous challenges in advancing their integration planning efforts. Some of these challenges include the following:

(1) Lack of working models for unique systems within California.

(2) Lack of start-up capital for initial design, actuarial analysis, and technical consultation.

(3) Lack of experience in designing an integrated, capitated, at-risk model for this population.

(4) Incomplete information about the target population and costs.

(c) The LOGs have stated that they require funding, information and technical assistance, and would benefit from sharing information regarding options for governance, financing, risk-sharing, federal waivers, service delivery, and management information systems, among others.

(d) Some planning efforts may be less expensive when completed by multiple counties simultaneously, and the LOGs can learn from each other by sharing their successes and failures.

(e) The State Department of Health Services has resource limitations on the technical assistance it can provide to the LOGs.

(f) It is in the interest of the state to accelerate the development of long-term care integration pilot projects (LTCIPPs).

(g) The state wishes to encourage a public-private partnership in establishing the LTCIPPs.

(h) It is therefore in the interest of the state to develop a public-private partnership to facilitate and foster the development of LTCIPPs.

SEC. 108. Article 4.5 (commencing with Section 14145) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.5. Development and Implementation of Long-Term
Care Integration Pilot Projects

14145. (a) Beginning with the 1998–99 fiscal year and contingent on appropriation of funds through the Budget Act, the department may contract with a nonprofit entity, incorporated in California that has been formed for the purpose of serving as the center for long-term care integration. The center may serve as a focal point for facilitating the development of community-based local organizing groups through a public-private partnership.

(b) The nonprofit center may do all of the following:

(1) Serve in an advisory capacity to the key stakeholders in long-term care integration, including consumers, consumer advocacy groups, researchers, representatives of service providers and purchasers, and local and state policymakers.

(2) Assemble, organize, and make available technical information, data, expertise, and models on long-term care integration from across the state and nation.

(3) Assist local communities with long-term care planning and analysis, development of service delivery and financing systems, statewide data sharing, and private fund development.

(4) Coordinate goals and activities with the State Department of Health Services.

(c) The center may build and sustain working partnerships by developing and supporting a cross-county, statewide network of consumers, providers and funders, as well as maintaining an ongoing relationship with the state.

(d) The center may assist the local organizing groups (LOGs) in seeking local financial support, as well as to obtain foundation matching funds for statewide grant-making.

(e) The center may coordinate and disseminate long-term care planning information by identifying key long-term care development issues, and disseminating the information to local planning groups, as needed.

(f) The center may facilitate implementation by identifying and sharing useful tools and resources, designing models for service

protocols of the local long-term care integration pilot projects, coordinating information systems, standardizing assessment elements, and providing low-cost training and technical assistance to the LOGs as they progress through common tasks necessary for local development and implementation.

(g) The center may collect and track information across LOG sites.

(h) The center may prepare annual progress reports, and shall provide these reports to the department and the budget committees of the Legislature.

14145.1. (a) The department may administer grants for purposes of this article, that shall be awarded through a request for application process.

(1) Grants may be awarded to local organizing groups (LOGs) that are existing or new community-based nonprofit organizations or government entities for purposes of implementing long-term care integration pilot projects, pursuant to Article 4.05 (commencing with Section 14139.05).

(2) Grants may be available for LOGs in the planning phase, or the development phase of the project, or both. Planning phase grants shall be limited to a maximum award of fifty thousand dollars (\$50,000). Development phase grants shall be limited to a maximum award of one hundred fifty thousand dollars (\$150,000). The planning phase includes activities related to initial planning for a long-term care integration pilot project (LTCIPP). The development phase includes activities for implementing the planning phase, up to actual implementation of the pilot project.

(b) Criteria for grant selection shall include, but not be limited to, the following:

(1) For planning phase grants:

(A) Identification of a LOG committed to development of a LTCIPP that includes major stakeholders, including, but not limited to, consumers, community-based providers, institutional providers, and public entities.

(B) Evidence of local government support for development of a LTCIPP.

(C) A description of current and planned consumer involvement.

(D) A plan for the use of funds.

(E) Specification of goals and objectives, and a work plan for achieving them.

(F) A proposed strategy for project evaluation.

(2) For development phase grants:

(A) Identification of the authorized grantee sanctioned by the local government entity.

(B) Identification of an entity for operation of the LTCIPP.

(C) Definition of a governance structure.

(D) An adopted work plan that includes all of the following:

(i) A vision statement describing the long-term care system for the community.

(ii) Description of the covered scope of services and programs to be integrated at the local level.

(iii) Description of the target population.

(iv) Plan for integration of funding for those services.

(E) Specific work goals for the development phase.

(F) A work schedule for completion.

(G) A proposed strategy for project evaluation.

(3) Both planning phase and development phase grant funds may be used for, but are not limited to, the following purposes:

(A) Staff support.

(B) Consulting contracts.

(C) Community organizing support.

(D) Data Analysis.

(c) Grantees shall be required to match a portion of the grant awarded, either with cash, or in-kind contributions totaling 20 percent of the total grant. The match required by this subdivision shall be supplemental to the funds appropriated for the LTCIPP.

(d) On or before March 1, 1999, the department shall provide the Legislature with a status update on the progress of the grant program process, including grant awards and any administrative concerns.

SEC. 109. Section 14163 of the Welfare and Institutions Code, as amended by Chapter 71 of the Statutes of 1998, is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) "Eligible hospital" means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) “Transfer year” means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) “Transferor entity” means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) “Transfer amount” means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) “Intergovernmental transfer” means a transfer of funds from a public entity to the state, that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) “Licensee” means an entity that has been issued a license to operate a hospital by the department.

(12) “Annualized Medi-Cal inpatient paid days” means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) “Medi-Cal acute inpatient hospital day” means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(14) “OBRA 1993 payment limitation” means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164.

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any provision of law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$239,757,690) for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars (\$154,757,690) for the 1997–98 fiscal year.

(D) In the amount of one hundred fourteen million seven hundred fifty-seven thousand six hundred ninety dollars (\$114,757,690) for the 1998–99 fiscal year and each fiscal year thereafter.

(E) The transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-001 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year issued by the department pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. The department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities

by the department shall meet the requirements set forth in subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98, exclusive of the amounts described in paragraph (2) of this subdivision, and to satisfy the requirements of paragraph (2) of subdivision (d), for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(F) The following provisions shall apply for certain transfer amounts relating to nonsupplemental payments under Section 14105.98:

(i) For the 1998–99 transfer year, transfer amounts shall be determined as though the payment adjustment amounts arising pursuant to subdivision (ag) of Section 14105.98 were increased by the amounts paid or payable pursuant to subdivision (af) of Section 14105.98.

(ii) Any transfer amounts paid by a transferor entity pursuant to subparagraph (C) of paragraph (2) shall serve as credit for the particular transferor entity against an equal amount of its transfer obligation for the 1998–99 transfer year.

(iii) For the 1999–2000 transfer year, transfer amounts shall be determined as though the amount to be transferred to the Health Care Deposit Fund, as referred to in paragraph (2) of subdivision (d), were reduced by 28 percent.

(2) (A) Except as provided in subparagraphs (B), (C), and (D), for the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental payment adjustment amounts of all types that arise under Section 14105.98. These increases shall be paid only by those transferor entities that are licensees of hospitals that are projected to receive some or all of the particular supplemental payments, and the increases shall be paid by the transferor entities on a pro rata basis in connection with the particular supplemental payments. For purposes of this paragraph, supplemental payment adjustment amounts shall be deemed to arise for the particular transfer year as

of the date specified in Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(B) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.96 shall be funded as follows:

(i) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(ii) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the “other public hospitals” group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this 1 percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.

(iii) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(C) For the 1997–98 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustments described in subdivision (af) of Section 14105.98 shall be funded by a transfer from the County of Los Angeles.

(D) (i) For the 1998–99 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustment amounts arising under subdivision (ah) of Section 14105.98 shall be increased as set forth in clause (ii).

(ii) The transfer amounts otherwise calculated to fund the supplemental payment adjustments referred to in clause (i) shall be increased on a pro rata basis by an amount equal to 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d).

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any

particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide data base file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 or 128735 of the Health and Safety Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 or 127285 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 443.31 or 128735 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) Transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal state plan.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars (\$15,000,000).

(6) Notwithstanding any other provision of law, except for subparagraph (D) of paragraph (2), the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in subdivision (d).

(7) (A) Except as provided in subparagraphs (B) and (C) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars (\$2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities:

(C) With respect to those particular amounts in the fund resulting solely from the provisions of subparagraph (D) of paragraph (2), the department shall determine by September 30, 1999, whether these particular amounts exceed 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d). Any excess amount so determined shall be returned to the particular transferor entities on a pro rata basis no later than October 31, 1999.

(D) Regarding any funds returned to a transferor entity under subparagraph (A) or (C), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments.

(2) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. However, for the 1997–98 and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in the form of periodic installments according to a timetable established by the department. The timetable shall be structured to effectuate, on a reasonable basis, the prompt distribution of all nonsupplemental payment adjustments under Section 14105.98, and transfers to the Health Care Deposit Fund under subdivision (d).

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(3) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with the health care provider, shall be channeled through a transferor entity or any other public entity to the fund, unless the donated funds will qualify under federal rules as a valid component of the nonfederal share of the Medi-Cal program and will be matched by federal funds. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the

nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All transfer amounts received by the Controller or amounts offset by the Controller shall immediately be deposited in the fund.

(l) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164, shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) Except as otherwise permitted by state and federal law, no transfer amount submitted to the Controller under this section, and no offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars (\$10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Services to be used to support the development of managed care programs under the department’s plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity, and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department’s plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) shall meet the objectives of the department’s plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the medicaid program.

(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. The claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity’s respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity's claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.

(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity's completed claim and supporting documentation. Prior to final determination, there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

SEC. 110. Section 16809.45 is added to the Welfare and Institutions Code, to read:

16809.45. (a) In addition to those powers specified for the County Medical Services Program Governing Board, as set forth in Section 16809.4, the board may contract with the department for interfund transfers and joint or shared use of fiscal intermediaries, as may be needed, to provide for the continuous and uninterrupted operation of the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 3 of the Insurance Code) and the Children's Treatment Program otherwise authorized by law.

(b) This section shall become inoperative on July 1, 1999, and as of January 1, 2000, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2000, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 111. (a) The sum of two million six hundred thousand dollars (\$2,600,000) is hereby appropriated from the Proposition 98 Reversion Account to a consortium of county offices of education, on a one-time basis, for three-year grants, beginning with the 1998–99 fiscal year, for the purpose of supporting technical assistance and focussed group training to teach school district personnel how to maximize reimbursements of federal funds for Medi-Cal services and case management.

(b) (1) There is hereby created, for purposes of this section, a technical advisory committee, which shall be composed of one representative from each of the 11 school superintendent regions, representatives from appropriate state departments and agencies, representatives from various school health and social services organizations, four members representing large school districts, four members representing medium school districts, four members representing small school districts, and representatives from various parent and community services organizations.

(2) Expenses for the technical advisory committee created pursuant to paragraph (1) shall not exceed forty-five thousand dollars (\$45,000) per year of the funds appropriated by this section.

(c) For the purposes of making the computations required by Section 8 of Article XVI of the California Constitution, the appropriation made by subdivision (a) of Section 41202 of the Education Code, for the 1997–98 fiscal year, and included within the “total allocations to school districts and community college districts from General Fund proceeds of taxes appropriated pursuant to Article XVIII B,” as defined in subdivision (e) of Section 41202 of the Education Code, for the 1997–98 fiscal year.

SEC. 112. (a) The State Department of Health Services may adopt emergency regulations to implement this act in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) (1) The State Department of Health Services may adopt emergency regulations to implement any new Medi-Cal benefits established by the Budget Act of 1998 in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) In the regulations described in paragraph (1), the department may define terms and prescribe requirements applicable to those benefits, including, but not limited to, the following:

(A) The provider types and size of provider office that are eligible for payment for providing this benefit.

(B) The criteria required to be met for payment.

(C) The reimbursement rates for the services.

(D) Any certificate or license requirements that are required to be met by individuals providing the services.

(c) The initial adoption of emergency regulations described in subdivisions (a) and (b) following the effective date of this section and one readoption of those initial regulations shall be deemed to be emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The

emergency regulations authorized by this section and the readoption of those regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 180 days.

SEC. 113. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars (\$1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 114. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to provide for the administration of this act relating to health care for the entire 1998–99 fiscal year, it is necessary that this act go into immediate effect.

